REPORT RESUMES

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DAY-CARE REHABILITATION CENTER FOR EMOTIONALLY DISTURBED ADOLESCENTS. FINAL REPORT.

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IN THIS FIVE YEAR DEMONSTRATION PROJECT, EMOTIONALLY DISTURBED ADULTS AND ADOLESCENTS RECEIVED TREATMENT AT A DAY CARE REHABILITATION CENTER SPONSORED BY THE RHODE ISLAND DIVISION OF VOCATIONAL REHABILITATION (DVR) LOCATED IN A PRIVATE PSYCHIATRIC HOSPITAL (BUTLER HOSPITAL). THE MAJOR TREATMENT GOALS WERE PRESERVATION AND RESTORATION OF INTERPERSONAL RELATIONSHIPS IN AN ENVIRONMENT OF LITTLE STRUCTURE, FREE CHOICE, MANY ACTIVITIES, COMFORT, AND SECURITY WHERE INDIVIDUAL AND GROUP THERAPY WERE AVAILABLE. PATIENT SELECTION, ADMISSION CRITERIA, AND REFERRAL PROCEDURES ARE DISCUSSED. DAY-CARE STAFF DESCRIPTIONS INCLUDE THE HOSPITAL SUPERINTENDENT, DIRECTOR, ASSISTANT DIRECTOR, HOME ECONOMIST, PAINT SHOP SUPERVISOR, BOOKBINDER, WOODWORKING INSTRUCTOR, SCHOOL TEACHER, HOMEWORKER, SOCIAL WORKER, PSYCHOLOGIST, DVR COORDINATOR, AND COUNSELORS. THE INSERVICE TRAINING PROGRAM FOR REHABILITATION COUNSELORS IS DESCRIBED. THE PHILOSOPHY OF DAY CARE, THE EVOLUTION OF ITS THEORETICAL FRAMEWORK, AND THE ATTITUDES OF THE STAFF TOWARD THE PROGRAM AT THIS CENTER ARE DISCUSSED. A TYPICAL DAY OF A PATIENT AND BRIEF CASE STUDIES OF 20 PATIENTS ARE PRESENTED. (JK)

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FINAL REPORT
OF
DAY-CARE REHABILITATION CENTER
FOR
EMOTIONALLY DISTURBED ADOLESCENTS

OVR PROJECT GRANT RD -550 - 60

June 1, 1960 - May 31, 1965

Conducted at Butler Hospital, Providence, Rhode Island
in collaboration with
The Rhode Island Division of Vocational Rehabilitation
George F. Moore, Jr., Chief

Under the Administration of:

J. Sanbourne Bockoven, M. D. (Acting Superintendent at time of original application)
Charles H. Jones, M. D., (Superintendent June, 1960 - March, 1964)
William V. Van Duyne, M. D. (Acting Superintendent March, 1964 - May 31, '65)

Submitted by

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I. INTRODUCTION

A. Background

The OVR project RD -550-60, a Day-care Rehabilitation Center for Emotionally Disturbed Adolescents was undertaken jointly by Butler Hospital and the State Division of Vocational Rehabilitation for a period of five years, June 1, 1960 - May 31, 1965. This project resulted from the success of a former OVR grant, #SP-182-C, Evaluation of Combined Physical and Mental Rehabilitation in a Health Center. This project served to prove how effectively a state agency and a private hospital could work together producing valuable learning experiences for both and a multitude of diverse services to rehabilitation clients. It pointed out the need and feasibility of the agency being connected with a psychiatric service to provide optimum treatment to its vast number of clients. The association between Butler and the DVR has also made the rehabilitation counselors more aware of the importance of psychiatry in the community, not only in dealing with referred clients, but also in counseling the vast segment of the population they encounter.

Butler had the advantage of its complete facilities in undertaking the project. It also had at its disposal a complete staff of social workers, psychiatrists, a psychologist, nurses, and activity therapists. The cooperation of all these people contributed to the functioning of the Day-care program. Through the DVR it was adequately supplied with clients to be treated on the program, and through its service as an in-patient hospital, it received further referrals for the Day-care program. In this report we will attempt to show the types of clients that used the Day-care program, and how effectively it was utilized.

The object of this demonstration project in a private psychiatric hospital involved the establishment and implementation of a Day-care rehabilitation center for emotionally disturbed adolescents, age 15-21, whose illness constitutes a vocational handicap or prevents continuation in school. The aim is to demonstrate the goals that can be achieved in providing mental health facilities to a state agency, in this case the Division of Vocational Rehabilitation.

Recent developments in the treatment of emotional disturbances emphasize the socio-psychological nature of the condition. Treatment focuses upon the preservation and/or restoration of interpersonal relationships, with efforts being directed toward providing complete treatment in a day-care environment of free choice, thus eliminating the need for commitment to a mental hospital. It is felt that the evolution of psychiatric services has been constituted, not by the discovering of new technical devices, but by the gradual exploration of the framework of human activity.

Collateral to the major objectives of demonstrating the practicality and value of such a program additional objectives had been originally suggested.

1. Assist the development of an informal, in-service training program for vocational rehabilitation counselors in Rhode Island.

2. Investigate the psychiatric and socio-cultural aspects of dependency in relation to personality, school and work performance

of adolescents referred for Day-care.

3. Analyze the range of personality types and life crises precipitating motivational and adjustment problems by comparing adult and adolescent case histories.

4. Evaluate and discover the most effective type of staff and facilities for Day-care treatment.

B. Setting

The setting of this project has been Butler Hospital, a hundred and twenty year old private psychiatric hospital with a seventy bed capacity, but offering also out-patient therapy, diagnosis, evaluation, weekend hospital care and consultation. The hospital's facilities include a wooded and landscaped area of about one hundred and fifteen acres and numerous buildings. The accompanying aerial view of the Butler complex gives one the picture of the total expanse of the hospital facilities. It is a beautiful setting, located in the heart of the East Side, the finest residential and cultural section of Providence, It is located near Brown University, which has always offered the hospital its support and use of its library and other facilities. In fact, the Butler Board of Trustees has always included a member of the faculty of Brown in order to keep the two institutions in closer touch. In recent years, a member of the Sociology Department was hired as a Consultant in Sociology and was actively involved in the Day-care project.

The hospital was founded in 1844, and for many years was operated strictly as an outstanding private institution with excellent treatment and the highest quality care. It was a teaching and research center, with many outstanding psychiatrists in the country being graduates of its residency program. However, it was a traditional hospital, offering specialized services to those patients who could afford it, but was not involved in community mental health problems. In 1955, it became necessary financially to close Butler Hospital. When it reopened two years later, it charted its course with a new philosophy, hoping to treat all classes of people. Changes in the treatment of the mentally ill, brought new changes in hospital administration, and Butler was anxious to associate itself with the new trends in psychiatric thought. Progressive purposes and goals were set forth with new and dynamic leadership. Reseacch grants were obtained, and through the first of these, the Day-care center was established. The State Division of Vocational Rehabilitation entered into an agreement with Butler under which many clients were referred for evaluation and possible treatment. Butler became the psychiatric arm of the rehabilitation division.

Butler hospital had always existed as a large complex of many buildings. When the hospital was reopened in 1957, many of these buildings were rented to health, social and welfare agencies. It was hoped that those agencies which had similar goals could work together, conduct joint meetings, and provide a smoother functioning referral process for many clients, The agencies renting space include: United Fund, Sophia Little Auxiliary, Girl Scouts of R. I., R. I. Heart Association, Narragansett Council of Campfire Girls, R. I. Mental Hygiene Service, American Cancer Society, R. I. Council of Community Services, Big Brothers of R. I., Providence Child

Guidance Clinic, Jewish Family and Children's Service, Providence Youth Progress Board, International Medical Care Study of Harvard University, American Mathematical Society, R. I. Division of Alcoholism, Institute of Health Sciences of Brown University, Family Services, R. I. Society for Crippled Children, and United Cerebral Palsy of Rhode Island.

C. Review of Literature

An intensive review of literature related to Day-care provided many aspects of similar programs. There was no available material on programs similar to Butler's unstructured system which is a relatively new concept. However, the atmosphere or environment is the key to the Butler program, and although programs differ at each hospital, there was much stress in the literature on the environment most conducive to rehabilitating emotionally disturbed patients. The Expert Committee on Mental Health of the World Health Organization concluded in a recent report that:

> "the most important single factor in the efficacy of the treatment given in a mental hospital, appears to be an intangible element that can only be described as atmosphere."

Thus, the atmosphere in a Day-care center is as important as it is in the total hospital picture.

A simple but precise definition of the Day-care center is expressed by Harris:

> "a place in which the patients spend a substantial portion of their waking time under a therapeutic regime and from which they return to their own homes to sleep at night."[1]

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1. Harris, A., "Day Hospitals and Night Hospitals in Psychiatry," Lancet, i, 729-730.

In 1945, Dr. Joshua Bierer started experimenting with Day-care centers attempting to extend the principles of social psychiatry to the everyday treatment of patients. In describing his Day Hospital, he states:

> "It is built on a belief in complete and free interaction of the two sides of the human personality, the physioanatomical and the psychological...One of the aims is to bridge the dichotomy between sole concentration on the individual on one hand and sole concentration on the group on the other...It is the first treatment form which is wholly non-verbal, and aims at the immediate experience as a therapeutic means and is mainly staged as a part of a normal social setting."[2]

Greenblatt, Landy, Hyde, and Bockoven state:

> "Research in social psychiatry and the experience of the hospital and its out-patient clinic, indicate that many persons in the community too sick to adjust under normal conditions can make use of hospital facilities as part of a total treatment program without the necessity of total hospitalization with its stigma and inherently disruptive influence on the family and social structure."[3]

The recognition of new approaches in treating the mentally ill is noted by Patterson:

> "Treat the patient as a human being, as a person with respect for his personality, individuality and humaness, with interest and attention to his social-psychological needs, feelings and concerns. The terms social psychiatry, therapeutic milieu, have been used to refer to the concern with the total social environment of patients. Results with the use of this approach

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2. Bierer, Joshua, "The Day Hospital," (H. K. Lewis & Co., Ltd., London, 1951).

3. Greenblatt, M., Landy, D., Hyde, R. W., and Bockoven, J. D., "Rehabilitation of the Mentally Ill: Impact of a Project Upon A Hospital Structure," The American Journal of Psychiatry, Vol. 114, No. 11, May, 1958.

> alone, without drugs, appear to be as spectacular, in terms of changes in behavior, as are those obtained by the use of drugs."[4]

There is much agreement on the importance of the social atmosphere and the proper setting of the rehabilitation center. There are moves away from the traditional hospital ward setup with accompanying recreation facilities. Beard and Goldman state:

> "settings which place a strong emphasis on the social milieu have something very special to provide the disabled psychiatric patient in his effort to re-establish himself."[5]

The first Day-Hospital in this continent was set up in 1946, by Dr. Ewin Cameron, at the Allan Memorial Institute in Montreal, Canada. Five years later, a similar day hospital was created by Dr. Moll, at the then new Montreal General Hospital. Both proved to be outstanding successes, and other hospitals soon followed.

The Poughkeepsie, New York psychiatric day hospital opened in July, 1956, in the Hudson River State Hospital under the neutral name of "Day Care Center." Despite its location on the grounds, the administration thought it important, at that time to dissociate the service in the public mind from the state hospital, and the center was given its own separate quarters, entrance, staff, and stationery.

The Butler Hospital Day-care program began in April, 1957. It was initiated with the cooperation of the State Division of Vocational Rehabilitation. It was:

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4. Patterson, C. H., "Implications of Developments in Psychiatric Treatment for Rehabilitation," University of Illinois.

5. Beard, J. H., and Goldman, E., "Evolving Concepts, Problems, Techniques, and Finances in Rehabilitation Programs for the Mentally Ill," Fountain House Foundation, Inc., New York, 1963.

> "devised primarily as an alternative to hospitalization to provide care and treatment for patients who could safely and beneficially spend their evenings at home. It was also recognized from the start to be an ideal setting for rehabilitation."[6]

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[6] Hyde, R. W., Bockoven, J. S., Pfautz, H. W., and York, R. H., "Milieu Rehabilitation," 1962.

II. PROJECT PROGRAM

A. Location and Description

The Day-care center for Emotionally Disturbed Adolescents is located in Ray Hall on the Butler Hospital grounds. It is connected to the main building of the hospital by a seldom used passageway, but primarily by an attractive courtyard. As pointed out on the accompanying floorplans, (Figures 1, 2, and 3), the Day-care unit utilizes three floors of Ray Hall or approximately 10,828 square feet of space. This building was originally used by the hospital for some recreational and occupational therapy facilities. Since the hospital reopened in 1957, it has increasingly become the center of occupational therapy and Day-care activities and has its own entrances, offices, and equipment. The Day-care patients do not have to go into the hospital unless they so choose. They have all their necessary facilities in the building with the exception of the gymnasium.

The main floor of Ray Hall is the center of Day-care activity. The building is arranged around a huge, auditorium-like room, which serves as a dance hall, a place for entertainment, ping-pong, and other table games. Off of this main section are the various crafts centers and offices. First is the arts and ceramics center. This area is widely used and contains excellent equipment. There are two modern kilns for producing ceramic items. Patients have decorated and painted whiteware and greenstone; some have utilized tile and brick; some have enameled metal in the form of ashtrays; and others have engaged in original sculptoring and creating. All of the necessary equipment is available for all mediums of painting. Some patients have discovered oil painting for the first time. One young man who was on the Day-care program became so involved with his painting that he decided to become a commercial artist. The DVR arranged for him to take a home study course in painting, which he successfully completed. He is now engaged as a commercial artist. Many adolescents find water coloring, oils, finger painting a successful outlet for their energy. They have produced some fine work,which has been exhibited periodically.

A living room area extends from the recreation center of Ray Hall to the sewing area. This is informally arranged with sofas, comfortable chairs, and a long dining room table with chairs. This section is usually the area where the patients and staff meet each morning. The table provides a useful function because it provides the group the opportunity to gather around in a family-like atmosphere. To the dining room table the patients bring their problems, their stories, and they use it to develop relationships with each other and with the staff. New patients often sit in the living room area until they become more acclimated to the environment. Some patients sit here all day, communicating with each other, and interacting. Some patients who have musical talent or ability bring their instruments and practice here or entertain the group. The daily newspaper is available as are weekly and monthly magazines of interest.

The psychotherapy room is also on the first floor. This is a large room arranged with chairs all around. Four group therapy sessions are held here each week. Private psychiatrists may see their patients here if they prefer to treat the patient in this building.

The sewing, or handicraft center is always a busy corner for the female patients. There are several sewing machines, a pattern cutting table, dressmaker tools, a wide variety of patterns, and even some fabrics. Most patients purchase their own materials when they are going to become engaged in some sewing project. Adolescents learn how to shorten their own clothing, redesign outdated fashions, and to create new patterns. It gives them a chance to use originality and initiative. Embroidery equipment is available, and some patients have completed tablecloths, towels, and other household supplies. More individual handicrafts are undertaken by patients who like to see their results sooner such as knitting and crocheting. Many of these articles have been displayed and occasionally sold at Christmas time in the hospital Coffee Shop.

A fully equipped modern kitchen is open to any interested patients. Two or three times a week cooking classes or special projects are planned on a more formal level. Often the patients enjoy preparing and serving a complete luncheon. This includes shopping, menu planning, cooking, setting and arranging an attractive table, and cleaning up. On holidays special desserts are made, and several times a week cookies or cakes are baked for the afternoon snack time. The cooking classes are useful for group projects, and for providing helpful hints to young housewives as well as teenage nutrition. New methods of cooking are discussed; new items in the markets are tested; and well balanced menus are planned. Every so often, the woodworking instructor uses the kitchen with a group of young men to cook some favorite dish. The male patients enjoy this task. The modern kitchen has proven to be a modality for both male and female patients.

Next to the kitchen is a fully equipped laundry for the use of the patients. It has a washing machine, a drier, and an ironing board. Teenage patients are taught how to take care of their own clothing. Occasionally male patients practice ironing their own shirts.

As can be seen in Figure 2, the second floor of Ray Hall occupies less space due to the large area of the auditorium. The classroom located here is the center of much activity. It is similar to a standard classroom, although on a smaller scale. It is surrounded by blackboards and bulletin boards displaying the work of the patients. The teacher's desk is at the front of the room, and there are about twenty desks and chairs facing it. Maps hang on the walls; there is a regulation globe; and there are several typewriters. Bookcases hold a wide variety of books including dictionaries, textbooks, basic reference books, art books, and some fiction. The classroom has all the basic tools and supplies to conduct a classroom situation. Some classes are conducted on a formal basis with several patients participating. More often, the teacher works informally with patients pursuing certain areas of study. The classroom has provided a relaxed atmosphere, one conducive to encouraging school dropouts to return to their education. It has given some patients a chance to explore a wide range of subjects and to find something of interest. Although the classroom is conducted with a minimum of control, the patients realize that they must respect each other and have developed their own code of conduct.

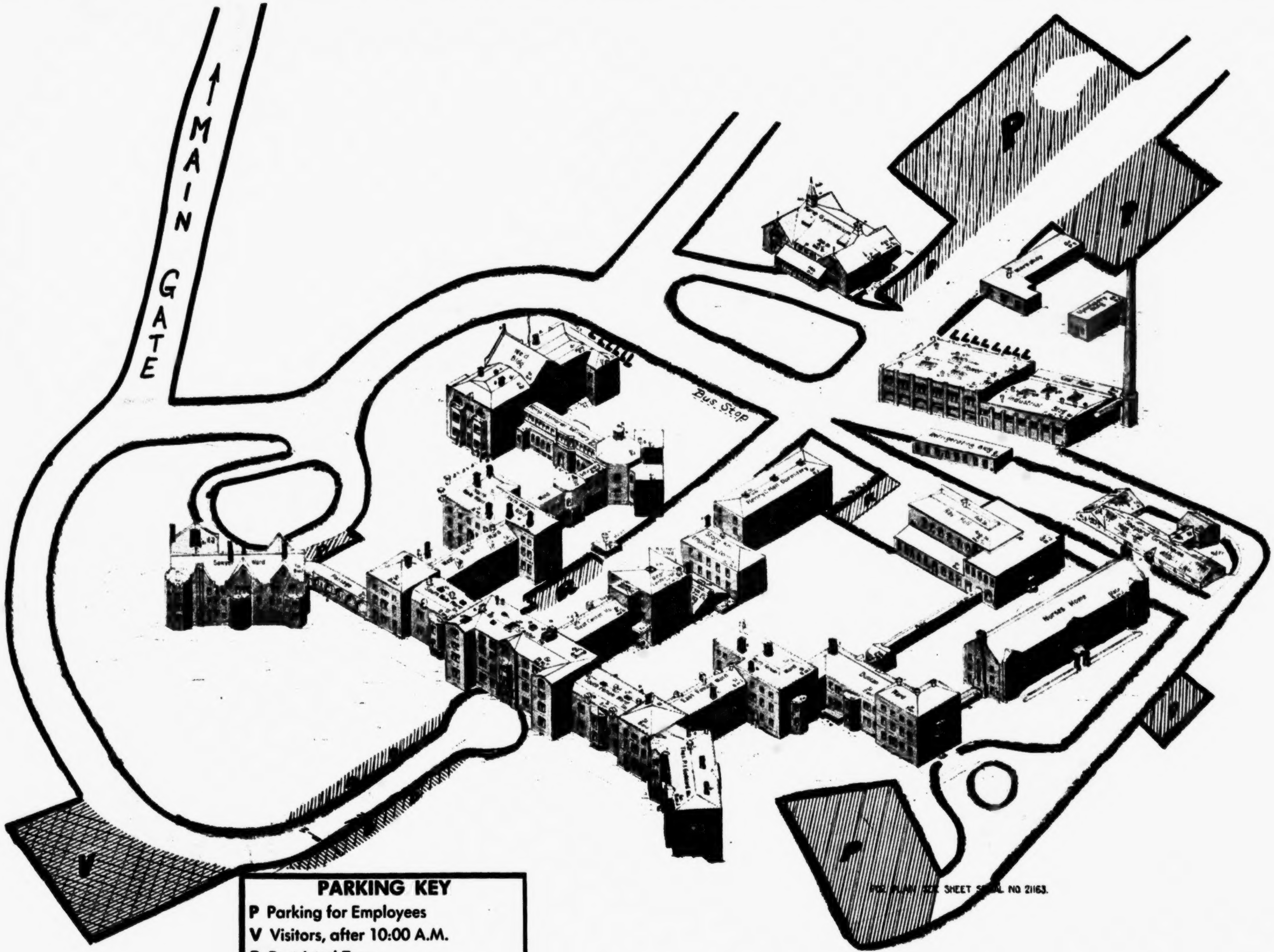
The print shop is in the basement of Ray Hall. It contains all the necessary equipment to print calling cards, posters, stationery, and other small items. At Christmas time many patients made and designed their own greeting cards. Printing, involving a careful arrangement of type, is a more difficult task for the patients. It provides more of a challenge and a greater power of concentration than some of the other activities. Patients often visit the print shop, spend a great deal of time watching and observing, become interested through their acquaintance with the staff, and gradually print something creative.

The woodworking shop is located near the print shop. Unlike printing, the tasks in the woodworking shop can be relatively simple. There are more intricate projects that people undertake, such as bookcases or summer funiture, but it is possible for a patient to begin an item, such as a spice rack or bookends and finish it in one or two days. The shop has excellent facilities with which to work including a bench saw, band saw, lathe, drill press, joiner, and planer. With these tools, the patients can create all kinds of practical or impractical things. They have made jewel boxes, magazine racks, wall shelves, chess boards, record cabinets, tables and chairs. Some patients create their own designs; some bring furniture from home to repair; and some refinish antiques. It is interesting to note that as many females as males receive satisfaction from this activity.

Not too far away from Ray Hall is the Kane Gymnasium. This fully equipped, recently modernized gymnasium, has facilities and room for many activities. It is used for basketball, volleyball, and badminton. At one time, the popular Providence College basketball team held an exhibition basketball game for the patients. In the basement are bowling alleys which are enjoyed by many of the adolescent patients. Every afternoon at 3:00 the Day-care program conducts a recreation hour which is the only formalized part of the program. The staff joins the patients in participating in a wide range of activities which encourage lessons in good sportsmanship and group interaction.

The greenhouse is situated directly across from Ray Hall and is easily accessible. It is fully heated and professionally constructed, with a fulltime gardener who supervises patients who become involved in planting activities. All year long beautiful plants are grown and developed. Some patients enjoy spending time in the greenhouse. They have started seeds of their own for herb gardens, been involved in transplanting, helped to water the flowers, and cut and trim the growing plants. The greenhouse has rich selections of ageratum, allyssum, marigolds, portulacas, petunias, snapdragons, chrysanthemums, etc. The flowers are used all year round throughout the hospital for floral decorations. Some patients have become interested in horticulture and learn how to make various arrangements. These have been used on holidays, at public meetings for centerpieces and in the wards. Some of the male adolescent patients enjoy working with the greenhouse staff in planting flowers on the Butler grounds and in mowing the lawns and planting grass.

The necessary facilities for an effective Day-care program are certainly available at Butler Hospital. Patients have their choice of which activities to select. The materials and the supplies are always ready; what will be done with these facilities will be up to the initiative of the staff, the motivation of the patient, and the cohesiveness of the program.


MAIN GATE
Bus Stop
P
P
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V
D
LLLLLLLL
LLLLL
Gymnasium
Industrial
Refrigerating Bldg
Henry C. Hall Dormitory
Staff and Employees Din.
Nurses Home
Duncan
Ward
Passage
Med Bldg
FOR PLAN SEE SHEET SERIAL NO 21163.

PARKING KEY

P Parking for Employees
V Visitors, after 10:00 A.M.
R Restricted Zone
L Loading Zone
D Doctors only

On street parking is not allowed. Violators will be *towed away.*

BUTLER HOSPITAL
Providence, R. I.

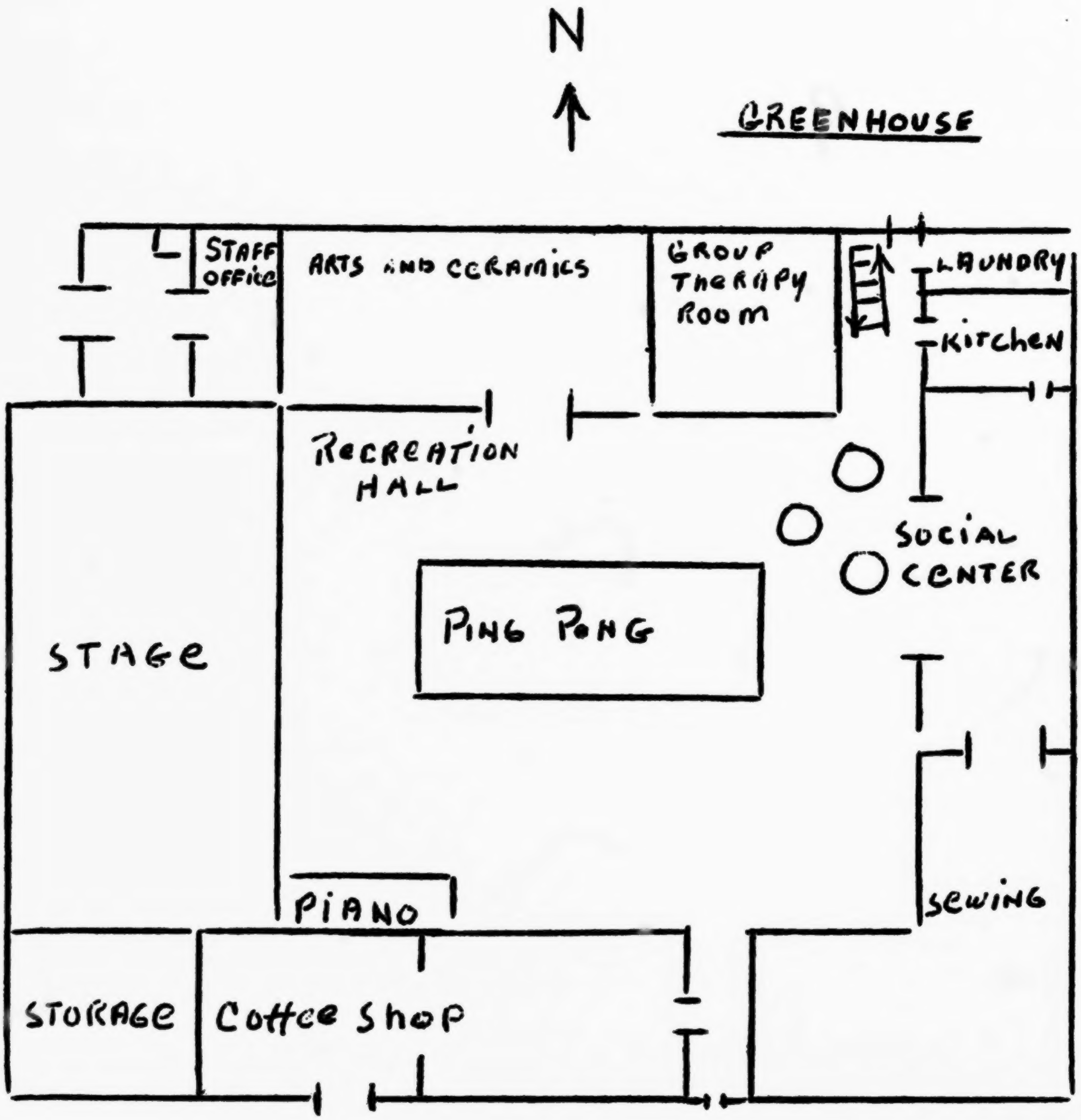
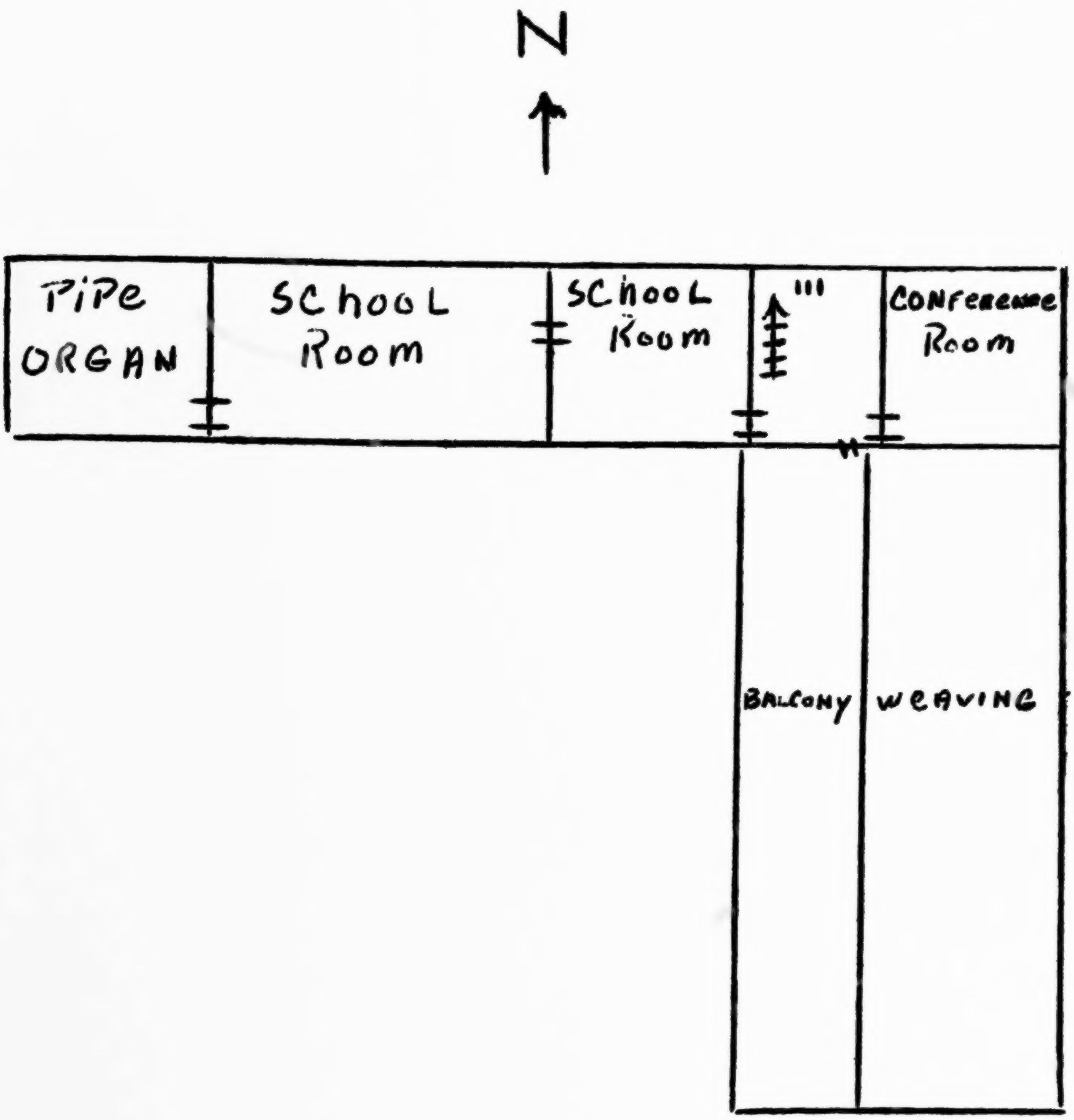

N
GREENHOUSE
STAFF OFFICE
ARTS AND CERAMICS
GROUP THERAPY ROOM
LAUNDRY
KITCHEN
RECREATION HALL
SOCIAL CENTER
PING PONG
STAGE
PIANO
SEWING
STORAGE
Coffee Shop

FIGURE 1. – FIRST FLOOR – DAY CARE CENTER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PIPE ORGAN
SCHOOL Room
SCHOOL Room
CONFERENCE Room
BALCONY
WEAVING

Figure 2. - Second Floor - Day Care Center

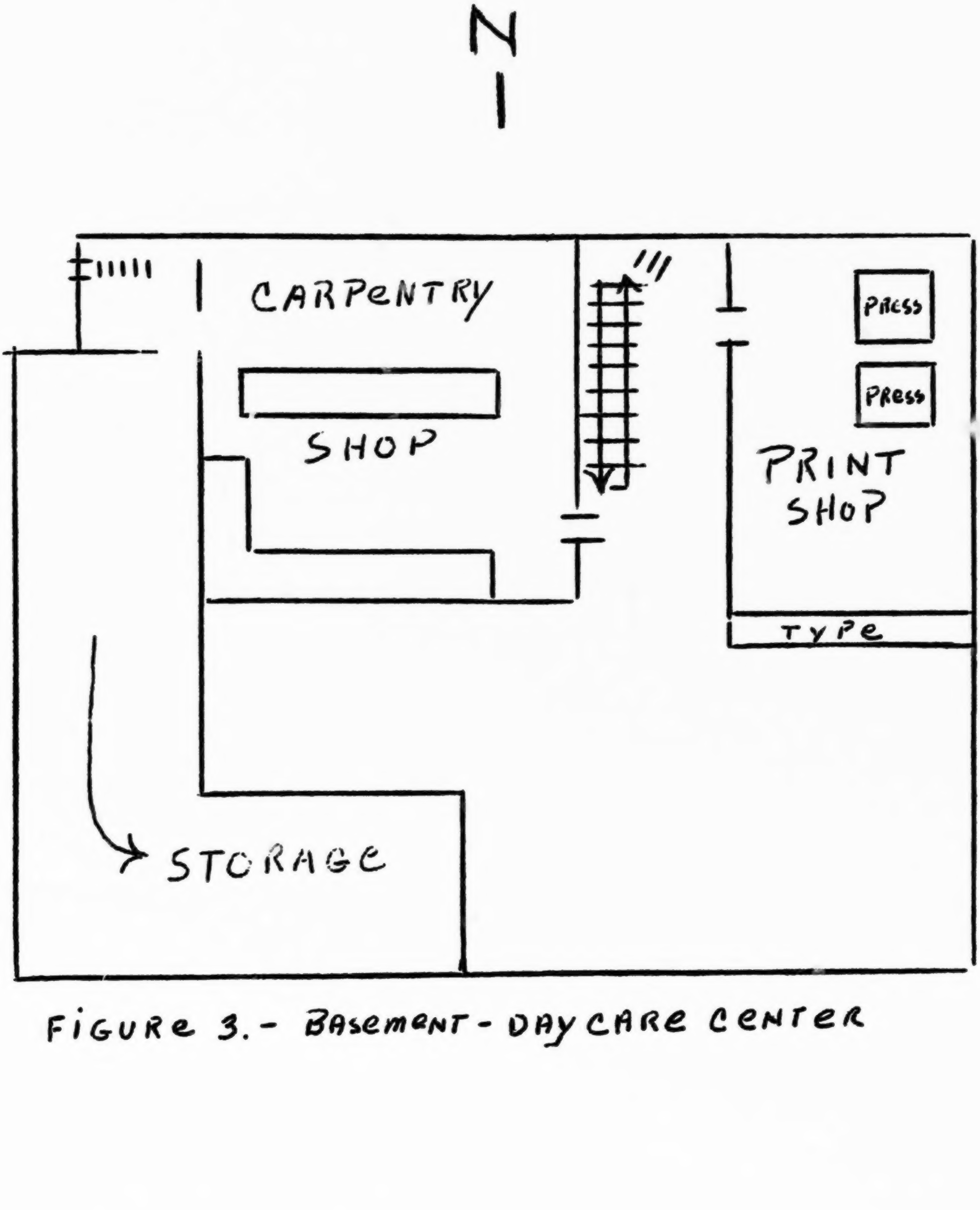
N
CARPENTRY
SHOP
PRESS
PRESS
PRINT SHOP
TYPE
STORAGE

FIGURE 3.- BASEMENT - DAYCARE CENTER

B. Criteria for Acceptance of Clients

How do the psychiatrists decide which clients should be accepted for Day-care services? What characteristics do the accepted clients have? What ideas were used by the physician in making his decision? In order to ascertain what criteria is used for acceptance of clients on the Day-care program, each psychiatrist on the staff was interviewed.

The first psychiatrist interviewed claimed that he only uses the Day-care program for adolescents. He does not approve of it for adults such as the heads of families or even housewives. He feels that other resources should be used for older people. He feels that the program is adolescent oriented, and as such, it should be only used for adolescents or people under thirty years of age. It can be an alternative to hospitalization, if the psychiatrist is willing to be in daily contact with the patient. In the case of one disturbed patient, he feels that is a place to keep her in order to prevent permanent hospitalization at a state institution. The Day-care program mobilizes her to a definite schedule of continuous activity five days a week. He feels it is a definite substitute for hospitalization for many severely ill people. In accepting Day-care clients from the DVR there is a tendancy to accept only those who are extremely well motivated because the others require long range planning and the program is not set up to render long range planning. On the whole, he refers adolescents with identity crises who have acting out behavior and are marginal delinquents. For these youngsters, he finds it an excellent milieu where disturbed adolescents can come in contact with sound individuals in order to develop their potentials.

Another psychiatrist interviewed stated that his criteria is different for private patients and for DVR patients. For the former, he very often uses the program as an alternative to hospitalization believing that, if possible, it is better to keep the patient in contact with his family. In regard to DVR patients, he feels that first of all, he is limited in the number of cases he can accept for administrative reasons. It is only possible to see a small number of cases and it would be virtually impossible to accept for service all those that are referred. Therefore, he has set up his own criteria of acceptance. The most important factor is the motivation of the client and whether or not he is perceptive enough to recognize the need for a change in his behavior and personality. Furthermore, the family of the client must be interested and willing to become involved in the treatment process if necessary. He also feels that many of the referrals are not bona fide referrals in that the clients do not initiate the psychiatric referral but rather are told to come and this influences his decision. Many of the youngsters also have severe problems, such as divorce, poverty, constant moving, and alcoholism in their families, and these problems must be separated from the psychiatric diagnosis. He feels that a one-month trial period is good to further evaluate the client and see how he adjusts to the program. These clients have to be people who are ready to transact with others in an interpersonal experience. The majority of this psychiatrist's referrals to the program are youngsters with passive-aggressive personalities who act out in school and do not get along with their parents. They are immature.

One of the newest psychiatrists of the Butler staff claimed that his criteria for acceptance depends upon the nature of the request from DVR. He states that some referrals are made specifically for a psychiatric evaluation, some are made to measure the stability of the client in an employment situation so that the counselor will be better equipped to counsel the client vocationally, and others are made with the hopes that the client will be suitable for the Day-care program. He said that less than half of the clients referred for Day-care are accepted. Many of those unsuitable for the program have low motivation and low intelligence. They would not profit from the therapeutic situation nor could they adapt to the milieu therapy of the Day-care situation. The clients that are most appropriate for Day-care are adolescents with maladjustment problems that might be clarified by their mixing with other people who have similar sorts of problems. The potential Day-care client does not have to be very intelligent, but he must have the motivation to want to find himself, to want to mingle with other disturbed individuals in the hope of improving himself. In some instances, clients are referred to Day-care because their home environment is disturbing to their function. It might be important to remove the client from the home atmosphere in order to have the opportunity to encounter different people and different situations. In the area of patient categories, this psychiatrist feels that he would never refer a manic personality because these people must relate on their own terms or they don't relate at all. They are having their own fantasy life and prefer to be by themselves. An inadequate defeatist would contribute nothing to the program and would not receive any benefit from Day-care. The mentally defective would not be helped and is better treated at other resources in the community. The ideal patient for Day-care is the relatively intelligent but unhappy and insecure individual, whose problems stem from his inability to relate to others; who wants to relate and become involved but is unable to do so. On the Day-care program, this individual meets up with others in the same circumstances, and through the unstructured program can learn to weather the storms of defeat and disappointment and emerge a more mature individual.

One of the psychiatrists who has been using the program for the greatest number of years and has witnessed its changes of program and philosophy, feels that his greatest use of the program is for patient trial periods. When he evaluates disturbed adolescents and adults that he feels might require hospitalization, he admits them to Day-care for a trial visit, in the hopes that they can improve and remain in the community. At the other end of hospitalization, he uses it to shorten the stay of hospitalized patients. It provides a means to earlier discharge because it is a link between the hospital and the community. He feels that the Day-care is an excellent place for adjustment for long term hospitalized patients. Some of the DVR referrals are people who have had long stays in the State Hospital and are not yet ready to face the competitive world. They require a slow movement back from their long term hospitalization, and a short period on Day-care might provide them a chance to develop self-confidence. Despite the fact that the program is unstructured, the very fact that it is a small group makes it a little society and, as such, through its attitudes and social pressures, it can develop in people who are uninterested in working a desire to become productive citizens. In the case of adolescents who are not accomplishing much in school, it is hoped that they will understand their rebellion, and through the influence and experience on Day-care, will receive internal motivation. In regard to the DVR clients, the ones that are accepted most readily are those people in a painful situation, reasonably intelligent and well motivated who want to do something about the fact that they are uncomfortable and are willing to go through more discomfort to get rid of their greater inner pain. Primarily, these people are passive-aggressive or passive-dependent personalities who want to be taken care of and are willing to admit it. There is a gratification for them in being dependent and in being helped. On the whole, these people are comparatively symptom free, have a productive potential, and are able to make some compromise with people around them.

Another psychiatrist stated that he refers few cases to Day-care because he feels that it is oriented toward adolescents. He has accepted for Day-care treatment those individuals who have difficulty getting along with people but were not verbal enough to work it out through therapy, so it could be approached through actions. In this way they can learn their problem through experience rather than through discussion. They are people who do not intellectualize but need the experience of interacting with other people. They know they have problems but don't really know why. In one case, it was used for a patient who had been hospitalized for a short period of time but was not ready for work. If she had remained at home, she would have spent the days lounging around and in bed. Through Day-care, she broke down her feelings of isolation and she became more tolerant of herself and other people.

The most recent psychiatrist to the Butler staff has not had a great deal of experience with the Day-care program, but feels that it satisfies a great need in the community. He feels that the DVR clients that he accepts are those who need a drastic change in environment. They might be people who come from an unhealthy home atmosphere, one in which there is little to do, and with few people with whom to communicate. It is obligatory that they mix with other people with similar problems in order to understand themselves and their relationships with others. He also accepts people who can use the Day-care program as an alternative to hospitalization, people who might be sick enough to be hospitalized but who can maintain themselves by being at the hospital all day but returning to the home at night. For many of these people, hospitalization means sickness, and a complete hospitalization would not serve to improve their condition but would make them sicker. Those people that he accepts might have situational reactions, such as being the middle child of three children and having felt rejected, but not have a great deal wrong psychiatrically. Schizophrenics do well on the Day-care by coming in contact with people, talking, and becoming occupied.

The final psychiatrist interviewed stated that the majority of patients he accepted were also of the passive-aggressive, passive-dependent personality type. They were patients whose illnesses began when they were about twelve years of age, who came from broken homes, with deaths in the family, disease and desertion. He feels that sociopaths are poor candidates for Day-care as are chronic alcoholics and individuals who have had many years of shuffling between the State Hospitals and other agencies. Many of these people are not strongly enough motivated to seek help, and they are appearing at Butler simply because another agency, in this case the DVR, is referring them. In most patients, the more discernable the pathology, the better the patient handles the environmental experience of the program. As the selection of the patients improved, the more the program was able to handle some peripheral patients. It is interesting to note that in the 1962 Application for Continuation Grant, it was reported that Day-care functioned mostly as an alternative to hospitalization in providing to adolescents who needed more than out-patient help but not needing intensive residential treatment, an intermediate psychiatric service. For another group of patients at that time, it existed in an essentially rehabilitative role; for some it provided a protected context in which to try out interpersonal skills dulled by hospital isolation; for others it constituted a refuge during a time of stress due to difficulties at home or in adolescence.

Although the project has altered greatly since its beginning, it is obvious by now that the prime function of Day-care is an alternative to hospitalization. The present staff of psychiatrists clearly designated this in their standards of criteria of patient admission. Closely allied to this, the Day-program is functioning as an environmental substitute for a weak homelife. It is being used as a testing and learning ground for various patients who have to explore their relationships with people. All of the psychiatrists interviewed expressed the need for strong motivation on the part of the patient and that this is a necessary quality for acceptance on the program. Without it, there is little chance for success.

C. Referral Procedure with DVR

The referral to the Butler Hospital Day-care Center originates in the office of the vocational rehabilitation counselor. The agency accepts many emotionally disturbed clients who have, in turn, been referred to them by private agencies, social or welfare agencies, or the schools. When the counselor accepts the case, he decides with the psychiatric consultant whether the client should be referred to Butler Hospital for evaluation or to a private psychotherapist. In recent years, DVR raised the psychiatric fee for psychiatrists and, as a result, more and more of the private therapists are working with the agency. This has served to lower the number of DVR referrals to Butler Hospital. However, in a study made recently, it was discovered that 26 out of the 32 DVR counselors refer to Butler. Most of the counselors make the referral in the hopes that the client will be found acceptable for the Day-care Rehabilitation Center for Emotionally Disturbed Adolescents. When the affiliation between

Butler Hospital and the State Division of Vocational Rehabilitation began, the counselors were referring clients with the intentions of having out-patient therapy or Day-care. Recently, the private therapists have been used for the therapy, and a psychiatric evaluation is sought at Butler when the client appears to be suited for Day-care. However, many more clients are referred to Butler than are accepted at the Day-care center. Many of the counselors are referring clients with deep social problems that are not truly psychiatric cases. In recent months, through the work of the DVR coordinator, the type of patient that can best utilize the center is being explained to the counselors, and there has been an improvement in the referral process.

When a counselor is going to refer a client to Butler Hospital for evaluation, he contacts the DVR coordinator and discusses the case with him. He gives the coordinator the nature of the problems, a brief social history, and the reasons for the referral. If the coordinator feels that the referral is appropriate, he contacts Butler and sets up an appointment with one of the staff psychiatrists. If the client is under twenty-one, he is accompanied to the hospital evaluation by a member of his family. This has been useful in providing the social worker with a more complete family background and social history. Through the family member, many details of the present situation can be discussed. It sheds more light on the entire problem. Furthermore, in some cases, it has been necessary for some member of the family to be involved in casework while the adolescent is attending the Day-care program.

After an appointment has been made for the client, the counselor is contacted and given the date. He must inform his client about the scheduled appointment, be told which doctor he is to see, and be prepared for the evaluation. Many people have misconceptions about why they "are being sent" to a mental hospital, and it is important that the counselor stress that this is an evaluation, and further plans will be discussed at a later date. In the past, some clients have thought they were going to receive a job, to be provided with job training, or to be hospitalized. Counselors are making greater efforts to keep their clients well informed.

The counselor must send the hospital all the pertinent information he has about the client before the appointment. This provides the social worker and the psychiatrist with the opportunity to know something about the client, have some details about his family life, be acquainted with his work history, and be aware of the trouble areas as seen by the counselor. If the client has been referred by another agency, these reports are also included. There are also photostats of any previous hospitalizations.

When the written evaluation is completed by the psychiatrist and the social worker, it is given to the coordinator, who interprets the results to the counselor. If the client is found to be unacceptable for Day-care services or out-patient therapy, the reasons are given. If the client appears to be appropriate for Day-care treatment, the recommendation is made, either for a trial period of one month, or as in most cases, a three-month period. The counselor contacts the client and plans are made as to when the program can begin.

When the client is ready to start the Day-care program, the authorization is provided by the coordinator. He also keeps a list of clients on the program with their starting and terminating dates. This way he can prepare reports in due time, so that if a renewal is needed, there will not be a time lapse.

On the whole, there is a two to three week wait for appointments for evaluation. However, in times of emergency or crisis, Butler has been able to supply immediate service.

D. Other Sources of Referral

The vast majority of cases on the Day-care program are referred from the State Division of Vocational Rehabilitation. There are some cases that originate in the hospital itself. These are patients who have been in the In-patient department for a period of months or weeks and are ready to leave this service. They are not ready to leave the hospital entirely, however, and the Day-care center provides an important link between hospitalization and the community. Some of these people are not yet ready for work or school and the Day-care center gives them the opportunity to test their strengths.

In some cases, patients enter the hospital with the intention of becoming In-patients, but the physician feels that it would be beneficial for the patient to remain at home nights but to be in the hospital days; perhaps the patient is not quite sick enough to require the complete hospital services. Some patients are border line cases, and although they are ill, the physician feels that being on the Day-care service will prevent further conflict and will be a form of prevention rather than hospitalization.

E. Job Definition on Existing Staff on Day-care Unit

1. Changes in the Administration of the Program

In the five years the Day-care Rehabilitation Center for Emotionally Disturbed Adolescents has been established, Butler Hospital has been in a constant state of change. In 1960 when the project was first undertaken, Dr. J. Sanbourne Bockoven was Acting Superintendent. He helped create the project with specific goals in mind and worked with the type of professional staff he felt was best suited to high quality treatment.

When he resigned from Butler Hospital, Dr. William V. Van Duyne became Director of the Day-care Program for a nine-month period of time. Having been deeply involved in administrative details, as the Clinical Director, no noticeable changes took place. However, every new Superintendent is faced with inevitable personnel problems which result in deviations in existing programs. The Day-care Program underwent various stages of upheaval along with the rest of the hospital.

In 1960, Dr. Charles H. Jones assumed the Superintendency of Butler Hospital and brought with him his own unique ideas about the administration of a private mental hospital. He had previously been associated with large state hospitals and his ideas of a Day-care Center were different from those in the original proposal. During his years the emphasis on Day-care changed substantially.

After his resignation, in February, 1964, Dr. William V. Van Duyne took over the position of Acting Superintendent. It was during this time that the Day-care Center began to assume its present position as a biological framework of choice. This was made possible by assigning the responsibility of Day-care to one psychiatrist, Dr. Hugh Crawford. Under his direction, with the cooperation of the Superintendent and other staff personnel, the Day-care Center for Emotionally Disturbed Adolescents became an integral part of the hospital and a self-sufficient multi-functional program. Although its operation was made possible by federal grants, it has grown to the point that it can stand alone. It receives patient support from the State Division of Vocational Rehabilitation, but is no longer financially dependent on outside sources. In this achievement alone,the project has been a success.

2. Changes in the Personnel

In the five years this project has been in operation, there have been many changes in the staffing of Day-care and in the administration of the program. During its first year, it was decided that each member of the Butler psychiatric staff be assigned patients from DVR in turn for evaluation for the Day-care Program, and in the event they were accepted, responsibility for immediate supervision would continue. Basically, this original policy has continued in regard to the evaluation and follow-up process. In regard to private patients sent for evaluation, they become the patient of that particular physician. Also, in the event that adolescents or adults on the Day-care Program receive In-Patient or Out-Patient care before or after Day-care acceptance, the same doctor continues in charge.

During the first year of the project, an experienced male psychiatric nurse was assigned to function as a group leader in the field of work assignments. He worked directly with heads of departments offering industrial assignments so that appropriate one-to-one working relationships were established. Thus, department heads were given specific patient assignments. This supervisor also worked himself with selected adolescents on group projects. He was in a position not only to arrange for the variety of programs prescribed by individual physicians, but also reported back to them as to the patient's progress, with the reports having the validity of being seen through the eyes of an experienced nurse.

In its second year of operation, two Day-care nurses, both registered nurses, one female, one male, had the leading role in directing the Day-care Program. The adolescents spent most of their time with these people who successfully carried out the roles of "Big Sister" and "Big Brother." At this time the nurses organized an adolescent group-session which met weekly. The details of the session were reported to the appropriate psychiatrist. A schoolteacher was on hand during the morning hours to conduct classroom sessions. Her only function was to lead the class, and she was at the Day-care Center on a part-time basis. There were, of course, the usual handicrafts and woodworking instructors, each fulfilling his own distinct task. During this time each psychiatrist mapped out a Day-care plan for each patient. Programs were rigidly followed by the personnel much in the manner of filling a medical prescription.

In the 1963 Application for Continuation Grant, it was reported, "During the third year of the project the training level of personnel rose markedly. Recruited to the program were a psychiatrist (bringing the total to five), a registered occupational therapist, a full-time schoolteacher and an additional social worker." The activities of the staff were beginning to develop more into the picture as it is existing today. An attempt was made to have a staff create an environment where adolescents could experience and test out situations which would come close to what they would experience at home, in school, at play, and at work. A male nurse, father of five children, became the supervisor of the Day-care program. He planned the patients' days in cooperation with the doctor. A female nurse was assigned the traditional role of the psychiatric nurse. She concerned herself with the physical and emotional needs of the patients. Both she and the supervisor had the responsibility of seeing that the patients followed their programs. A registered occupational therapist was added to the staff. Her role was manager and organizer of occupational and recreational activities. The part-time female teacher was replaced by a full-time male teacher whose role was primarily limited to the teaching process. The yearly report section, "Personnel Staffing of A Day-Care Program for Emotionally Disturbed Adolescents," concluded by describing the staff as one "whose function is to structure experiences within a definitely programmed day."

By 1964 the Day-care Program began to evolve into the shape it assumes today. One of the hospital psychiatrists became involved and interested in the Day-care Program, and began to invest his energy and ideas into the project. He felt that the Day-care Center should have its own identity, its own image, and be able to function on its own initiative. At first a well-trained group worker took administrative charge of the Day-care area. She, however, only remained at the hospital a short time, and her position was never filled. The physician who elected to direct Day-care became the force behind it. He chose to be associated with it because of the unique service he felt Day-care could render to patients.

3. The Director

For the last two years the Butler Day-care Program has had a physician as a Director who has made his headquarters within the Day-care area, and has been continuously and immediately available to the staff for consultation and advice. This has been partially responsible along with the influence of other staff members in changing the environment of the program as is being described.

The Director spends most of his time in the immediate Day-care Center, knows each patient by name, is aware of his problems and interests, and helps develop a climate of camaderie and free choice. He conducts group therapy sessions four times a week at the Day-care Center, and often sees his own patients in psychotherapy in this building. He was instrumental in bringing all forces of treatment together under one roof. He works closely with the members of the staff and conducts two formal and several informal staff meetings weekly at which the progress of the patients are discussed as well as the interaction of the personnel. By keeping in close touch with the patients, he is able to assist the staff accordingly. His participation has served as an impetus to broader ideas and understanding. The environment developed today is one of "patient impetus."

According to the Director, the patients on the program structure the very program itself.

4. The Staff

The staff recruitment was characterized by heightened sophistocation regarding the Day-care Program. Since the Day-care philosophy of little structure and free choice was a relatively new concept, it seemed appropriate to attract a different staff. In most cases, selection of the staff was based on motivation, interest in a new program, willingness to assume leadership without stressing authority roles, and a general attitude of belonging in the program. While most staffs are hired to function in relationship to the program, this staff was also developed to function with the patients. The patients and the staff work together to develop the framework of the setting.

The Day-care staff was hired and welcomed, but the patients retained the right to select whomever they chose to work with, to associate with, to work out his interpersonal relationships. The philosophy of "free choice" is inherent to the entire program as well as the staff. In relation to "free choice," Harry Stack Sullivan writes:

> "The individual has to do the choosing of his interpersonal material. The person is an object with subject capacity."[1]

In developing the Day-care staff, the Director was predicting the need to help medical personnel to extricate themselves from previous modes of thinking. The individuals hired were more interested in growth than success. While not always well trained, they have experimented quite a bit in finding themselves and are familiar with the pain of a person in growth and are familiar with the blind alleys a person in growth explores. They are properly supported in their therapeutic growth by the Director who is keenly aware of the needs of "persons in growth." All these people possess certain skills, but these are not as important as their ability in social relations; their involvement in interpersonal relationships with patients. They are sensitive people. In some cases there has been a meaningful, triangular relationship between one of the male workers, the doctor and the patient. The patients trust the worker, the worker works with the doctor and there is a working relationship.

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[1] Cf., Harry Stack Sullivan, The Interpersonal Theory of Psychiatry, (New York: W. W. Norton & Company, 1953, page 16).

5. Assistant Director

The Director's assistant at the present time is a thirty-two year old licensed practical nurse. She previously worked in the psychiatric unit of the Woonsocket Hospital wheee she worked with patients in rehabilitative and recreational areas. She also worked as an obstetrical nurse, but wanted to deal with people on a more personal level. She began her hospital work at Butler as a nurse, working with the in-patients on the ward. Here she had the opportunity to cope with more complex personalities and to understand their problems and behavior. At this time the Day-care Program was beginning to materialize, and since she possessed artistic skills along with her nursing background, the program offered a new challenge.

As the Assistant Director, she has certain administrative responsibilities such as taking daily attendance, administering drugs, which are delegated, and introducing new patients to the program. She is an efficient person who works closely with the Director to satisfy the needs of each individual patient. She regards her role as one of a companion or a communicator. She does not plot any program, she seldom requires patients to attend activities, but she tries, at times, to get withdrawn individuals interested in doing something. She helps create an atmosphere of comfort and security, necessary to growth.

Along with her administrative duties, the Assistant Director possesses certain skills in the artistic area which give her the opportunity to become more involved in activities with patients. The hope is to make the climate so conducive to participation that the patients will seek out the activities on their own initiative. In some patients encouragement might be deemed appropriate and attempts may be made to stimulate interest, but on the whole, the selection of activity remains a privilege of choice.

The Assistant Director also serves as a home economist or cooking teacher. Several times she prepares a dessert for the patients or even a special luncheon. This seems to be enjoyed by many of the adolescent patients. Not only do the adolescents enjoy this, but also the young mothers and housewives on the program have found this useful as a means of providing ideas for menu planning and new recipes. She sets the pace for all these activities and maintains a professional capacity, but relates to the patients in a relaxed and easy manner.

During the day she tries to be aware of the behavior of the patients. She studies the problems and the interaction of the personnel and patients. She records her observations and reports these to the staff meetings. In the discussions she contributes much information about the progress of each patient as she has observed them in the group situation.

6. Print Shop Supervisor

This staff member is a thirty-year old professional engraver and printer. He has studied at home and abroad and has worked professionally prior to his employment at Butler.

When he first came to Butler, he reorganized the print shop. Although he knew the equipment could not compare with a professional shop, he wanted to make it as comprehensive as possible so that it would be productive for stimulating active participation. He reactivated the old printing presses, ordered new equipment, arranged a more suitable floor plan and ordered new type. Before long, the print shop was functioning smoothly. Although the printer spends most of his time in the shop, he also socializes in the recreation area where he can get to know all of the patients. None of the staff members remain in an isolated niche or cranny, but rather try to utilize the entire Day-care area. They establish relationships with the patients in various group activities and social meetings, but use their skill to further the framework of choice.

The Print Shop supervisor also participates in the group therapy sessions with the Director. Originally, his function was simply that of operator of the tape recorder used to tape the sessions, but his presence proved to be useful. Certain patients identify easily with him and he became an important part of the group session.

7. Bookbinder

When the bookbinder joined the Butler staff, he intended to become a part of the occupational therapy department. He soon realized that the Day-care Program did not have the classical type of occupational therapy. The most meaningful aspect of his work was not bookbinding, but was becoming involved in interpersonal relationships.

The bookbinder also possesses skills in printing and he also helps in the print shop a great deal of the time. Afternoons he helps direct recreational activities and sports programs which are the only organized parts of the Day-care Program. He leads basketball or volleyball, or helps in bowling contests. In active participation in the recreation area, he can evaluate the group behavior of the patients.

8. Woodworking Instructor

He is a fifty-six year old carpenter by profession, expertly skilled in his trade. He found the competition and pressure of competitive business unrewarding, preferring the environment of the hospital setting. He is a warm person, perceived as a source of strength. He is the oldest person on the Day-care Program and represents a parental symbol. He is particularly liked by the adolescent male patients. Many of the boys on the program have depriving fathers in their homes or, in some cases, no fathers, and he represents a father. Many of our boys' mothers are destructive and the fathers are unproductive. The woodworking instructor represents security and acceptance. The tasks in the Woodworking Shop are sterotyped and undemanding. Patients tend to graduate from the shop. When they first arrive, they often find this the safest place to be. The tasks are simple, they can produce a finished product, and the instructor is a comfort. The more sophistocated patients tend to sidestep the woodworking shop. The instructor is able to describe in ingenious terms his insights about the patients.

9. The Schoolteacher

The present schoolteacher is a young man in his late twenties with great feeling for people. He originally worked in private schools and offers help in Latin, Algebra, English, and History. Unlike the other activity therapists, he had some previous mental hospital experience, having worked at the Brattleboro Retreat in Brattleboro, Vermont. He originally came to Butler as an attendant on the wards.

In the area of supportive tutoring, he works with different groups of people. There are the adolescents who are school dropouts but are anxious to explore a particular subject, such as Business Letter Writing, Mechanical Drawing, or some course of study which will help them in their employment goals. Other patients attend night courses while on the program, and use the schoolteacher to provide extra help and insight. There is always the hope that the classroom situation will inspire school dropouts to return to high school to seek their diplomas. The classroom is a place where older patients can practice and sharpen up their skills. They can pursue independent study. Some people practice French, others learn typing.

During recent months of the formal program, the schoolteacher spent one or more hours a day with one patient who is studying cuneiform. He was finding out whether in actually performing cuneiform she could find some expression of herself. The freeing of affects in one area was getting her to function more freely in other areas. Through her studying, a change was taking place within her.

The schoolroom is a constant place of activity for many patients who find its atmosphere free and inviting for learning, as well as those who enjoy it for its center of communication.

10. The Homemaker

The most recent staff member is called a homemaker but she, too, performs many functions along with her sewing, knitting, weaving, embroidering and cooking skills. She feels that she is not on Day-care to teach sewing and cooking lessons, but to be herself and to relate to the patients. She spent one year at Butler in the past as manager of the Coffee Shop, so she had an informal knowledge of the hospital setting. When she returned to the hospital, she wanted to work as a salaried employee. Therefore, she started on the ward and eventually became attached to the Day-care Program. The skills she possesses can be used to help patients experience a sense of accomplishment.

In the sewing area, she has established relationships with patients while they design patterns, remodel fashions, and select fabrics together. She helps them to gain self-confidence and to rely on their innate good judgment.

She enjoys the staff meetings, which she attends twice a week. The staff works well together and has a smooth interaction with the patient population. The staff is present to help the patients gain insights into themselves, but not to change the patients.

11. Social Worker

Until recently no one social worker has been assigned to work with DVR clients, but rather the entire social worker staff is involved in the interview process. When the DVR coordinator arranges an evaluation for a new client, the client is assigned a psychiatrist through the admissions office. At the same time, a social worker is assigned to the case. When the evaluation is performed by the psychiatrist, the social worker sees one of the family members of the client. If the client is an adult, and his husband or wife is not available, the social worker will see the client himself, after the psychiatric evaluation. The social workers prefer to see a family member because, through this third party, they can receive a more total picture of the nature of the problem, etc. Before the client comes to the hospital, the social worker is familiar with the case by having read all the background data supplied by DVR, and reports from other agencies or hospitals if the client has had other contacts. If the client is being referred by DVR through another agency, such as Family Service or Child Welfare Services, the social worker from that agency usually accompanies the client, and is able to furnish complete material on the case.

In some cases, after the client has been accepted for Day-care services, the client remains in close contact with the social worker. In certain cases social casework is a substitute for psychotherapy. In other cases, it is necessary for one of the members of a family to be in casework with the social worker while the adolescent is on Day-care. Many of the social workers maintain continuous contacts with the families of adolescent clients, acting as liaison between the client and the psychiatrist and offering supportive treatment while the youngster is on the program.

12. Psychologist

Butler has had the advantage of having a full time, qualified clinical psychologist. He has been available to provide complete testing for any client when it has been requested by the DVR counselor. Therefore, he is a part of the evaluative process. He is able to administer vocational tests as well as projectives and sends his reports to the DVR office. In most cases, however, if the client is going to be accepted on the Day-care Program, projective or personality tests are not administered. The psychologist takes part in the staff meetings and is useful in interpreting behavior patterns. The staff evaluates the client's abilities and interests through their own observations.

13. DVR Coordinator by Mr. Joseph Farrell

The role of the DVR Coordinator is a many-faceted one in that he is involved in administrative, liaison, and counseling activities. This writer has been assigned to Butler Hospital since June, 1964, and even though the project ended last June, he will continue in this assignment since the relationship between Butler Hospital and DVR is a desirous one. The Hospital is considered by many of us to be the "psychiatric arm" of the State Division of Vocational Rehabilitation. The evaluation service provided by the Hospital is a valuable one which allows the counselor to gain a better understanding of his client's emotional disorder. He is then better enabled to proceed with recommendations for treatment or other services which the doctors feel will be more beneficial. The counselor's understanding of psychiatric disorders in general and his client's problem in particular is enhanced through the evaluation procedure.

The two-treatment services, Out-patient therapy and Day therapy, will continue to be made available to our clients, and the counselors will continue to refer for treatment due to the good results, using the criterion of satisfactory functioning in employment, which have been achieved in the past.

When a counselor is thinking of referring a client to Butler for evaluation, he contacts the Coordinator and discusses the case with him. The outcome of this discussion is that the Coordinator will be able to determine which doctor to assign the client to, and he will give the counselor a definite time and date for the client to report to the doctor that is decided upon. If the client is under twenty-one, the counselor is advised that a parent must also be present to provide a social history. Through experience, it has been found valuable to have a pertinent family member present even when the person is of age because they present another side of the picture which the social worker and doctor can discuss before final recommendations are made. Sometimes it is quite important to involve the family member in casework while the client is in psychotherapy so that insight, understanding, and a type of empathy can be developed in the former which will be a definite asset and motivating force in the treatment of the latter.

After an appointment has been scheduled for his client, the counselor is advised to prepare his referral material on the client. This includes a cover letter, giving his impressions of the client and his reason for referral, along with copies of all pertinent case materials. This information should be given to the Coordinator a week before the scheduled appointment. In this way the doctor has a chance to review the material and thus avoids asking questions about background data during the interview. He can then better concentrate on an evaluation of the personality dynamics which are contributing to the client's inadequate vocational functioning.

The counselor is also advised to contact the client and inform him of his scheduled appointment and the doctor that he is to see. It may be noted that the client does not usually see the Coordinator first. This writer is the first Coordinator to have been assigned to the hospital on a part-time basis (about twelve hours a week or two and one half hours per day) and as a result, he is not able to be present when the majority of the clients come for their evaluation. Therefore, it was decided not to see clients before their evaluation. However, adequate preparation of the clients for the interview has been continually stressed by this Coordinator when speaking with the referring counselors. This approach seems to have been effective because there are very few instances where clients say that they don't know why they have been referred to Butler and in these instances it seems to be a defense mechanism used by the client to negate the presence of an emotional problem.

When a written report of the doctor's and social worker's impressions has been completed, it is given to the Coordinator who sees that the appropriate counselor receives it.

It is also the Coordinator's responsibility to arrange for clients to start in the two-treatment services (day-care and out-patient therapy) offered by the hospital. He also maintains a list of termination dates so that progress reports and final reports are received in time for uninterrupted continuation on the program or discharge from it. This is important because progress reports must be received far enough in advance for the DVR counselors to review them with a psychiatric consultant and also authorize a continuation if this is decided upon. The final reports are also very important because they allow the counselor to review what has transpired during the client's period of attendance at Butler and thus better enable him to work with the client toward his vocational objective.

While the clients are participating in the Day-care Program, the coordinator makes himself available to them for counseling or information. Since most DVR counselors do not come to see their clients on the program, it is felt that the Coordinator's avail-ability is essential to positive identification of the clients with the agency. The Coordinator has encouraged and will continue to encourage the counselors to visit their clients because the counselor-client relationship is the core of a successful rehabilitation endeavor. The Coordinator also attends a weekly meeting where the team approach is used in discussing the clients on the program and the problems encountered by Day-care staff members in their interactions with the clients. The information presented at this meeting along with the daily observations of the Coordinator are relayed to the DVR counselors who thereby are kept abreast of their clients' activities and movement in the program.

The liaison part of the Coordinator's responsibilities is an important function, which should not be minimized. In interpreting policies to both agencies, the Coordinator occupies a vital middle position. He has attempted to develop mutual understanding and respect. However, due to a lack of knowledge of each others' discipline, the Coordinator has run into difficulties on occasion. Some psychiatrists tend to limit their perspectives to the therapeutic aspect without considering the total vocational implications of the treatment program. The same is also true with some rehabilitation counselors due to a lack of understanding of the psychotherapeutic process. The Coordinator has attempted to narrow this gap through interpretation of Vocational Rehabilitation goals to the Butler staff and through his own increased awareness of psychiatry, which he interprets to the counselors. With regard to the latter, all new counselors spend a few hours with the Coordinator at Butler where they receive a comprehensive orientation which it is hoped will increase their awareness of this service area.

In addition to the duties which have been mentioned, the Coordinator also maintains a case-load of his own which numbers about 135 cases at the present time. It is composed entirely of clients with emotional problems with referrals coming from DVR, Butler Hospital, private psychiatrists, and community agencies. Since this type of disability area is difficult to work with, a lot of time is devoted to the counseling of these individuals which has to be the center of all efforts toward rehabilitation. The development of insight along with support and encouragement is a necessity for satisfactory adjustment and vocational rehabilitation. Therefore, the Coordinator does spend a considerable amount of time working with his own clients. These include several individuals who are involved in the treatment programs at Butler Hospital.

In conclusion, it is the feeling of this writer that the overall relationship with Butler and in particular with the Day-care program is adjunct to the physical restoration services of the State Division of Vocational Rehabilitation. Day-care offers an opportunity for clients with psychiatric disabilities to interact with one another and with empathic staff members who act as counselors or psychiatric aides in a group and individual framework. The clients also have an opportunity to participate in individual and group therapy with their therapist and in this manner solidify the gains which they have made in the milieu setting.

... It is felt that the ongoing association between DVR and Butler Hospital will be strengthened in the final analysis, a good service will become an excellent one.

Butler has a large staff of Associate Psychiatrists; i.e., psychiatrists in the community who have private practices but who may send their patients to Butler for hospitalization. Some of these private psychiatrists have referred their private patients to the Day-care center. We feel that this is a great potential for increasing the patient load in Day-care and it is hoped that in the future, through increased knowledge of the Day-care center, more and more of the private psychiatrists will refer patients. Day-care treatment is in many cases a substitute for the orthodox methods of psychotherapy, and psychiatrists who use it may have to readjust their thinking.

F. In-Service Training of Rehabilitation Counselors

During the five years' span of this project, the in-service training of the rehabilitation counselors has varied along with the other factors involved. At one time, the DVR coordinator had a permanent office at the hospital, and was on hand every day. He attended all the staff meetings, was present to meet all the clients, and was regarded as part of the "Butler team." In the last stage of the project, when a new coordinator was named, he was assigned to the hospital on a part-time basis. Although he still maintained an office, he was only at the hospital one morning and one afternoon a week. However, he participated in the Day-care meetings and was offered the same in-service training opportunities that had always been available to the coordinator.

The in-service training program related to the Day-care center, receives its stimuli from two aspects of the hospital-agency relalationship. One, from the direct referral process to Butler, and two, from the weekly conferences. Through the referral process and the diagnostic evaluation, the DVR counselors learn to understand the type of client that Butler Day-care can best serve. The referred client receives a complete evaluation from a staff psychiatrist. A member of the client's family is interviewed by the social worker. By referring clients to Butler and receiving complete evaluation reports, the counselors become familiar with psychiatric language, are exposed to diagnostic categories, and gradually become better equipped to refer more appropriate psychiatric clients.

At the conferences held weekly, the DVR coordinator and the counselors learn the realistic interpretations of theories studied and written evaluations. There are two weekly meetings to which the DVR personnel are encouraged to attend as part of the in-service training. The first is an informal meeting held at the Day-care center under the supervision of the Day-care director. Present at this meeting are all the members of the Day-care staff: the activity therapists, the schoolteacher, the social worker, the DVR coordinator, the rehabilitation counselors, and, on occasion, other staff psychiatrists. The meeting is conducted informally with emphasis on the day-to-day progress and behavior of the Day-care patients. Interaction of the patients and their relationship to staff members is explored and discussed. The director comments on the group therapy sessions, with staff members corroborating his insights with the introduction of various actions of the patients during their days' activities. If an unusual event has occurred, the staff may discuss how the different patients reacted. The motivation of the patients and their attitudes are discussed. There are no notes used by the staff, and the meeting serves to allow the staff the opportunity to understand their involvement with patients.

This meeting is a useful training service to the counselors who attend. They learn about the interpersonal relationships as they exist on the Day-care program. They understand the daily functioning of their clients and their attempts to conform to the environment. They are able to evaluate the progress of the individual patients, to note whether or not they are taking advantage of the program, and to understand the concepts of Day-care treatment. It makes them aware of the entire scope of the treatment program with emphasis on the milieu. It almost serves as a type of psychiatric residency for the counselors who experience first hand the workings and functioning of the rehabilitation process from its beginning. The meeting, with its complete staff, offers a mirror of the clients' activities, and the counselors have the opportunity to judge the value of the treatment to justify further extensions.

The second meeting held weekly at Butler, in the Isaac Ray Library, is a more formal meeting. In essence it is an evaluation meeting useful to rehabilitation personnel in many ways. The meeting is conducted by the clinical director of the hospital; he comments on and discusses with the staff all DVR evaluations of the previous week. Present at each meeting are the staff psychiatrists who performed the evaluation, the social workers who did the family interviews, the clinical psychologists, the assistant director of Day-care, the DVR coordinator, and the rehabilitation counselors who referred the clients who were evaluated. Each case is discussed from the original referral to DVR, with the counselor supplying pertinent information and his reasons for referring the client to Butler. The social worker then reads her social history background, commenting on her impression of the family life, and how the client's behavior has disrupted the home situation. The psychiatrist gives his evaluation, describing the interview with a clinical interpretation of the client with reference to the client's mood, physical characteristics, presence of organic disease, motivation and psychiatric diagnosis. At this point the psychiatrist gives his recommendation, which might be a.) Day-care for a three-month period, b.) Day-care for one-month trial with further evaluation, c.) psychotherapy in the out-patient department, d.) referral to another agency such as e.g. Community Workshops, e.) referred back to counselor for vocational appraisal and direction or f.) no treatment recommended. By attending this conference, the rehabilitation counselor is able to question the psychiatric recommendation and receive more details than he would in a written report. The psychiatrist might explain the vocational limitations of the client and even suggest an appropriate vocation to pursue. He can explain his reasons for not recommending treatment which may be on the grounds of lack of motivation, or perhaps the involvement of too many agencies on the case, or even a record of too many previous psychiatric hospitalizations without results. Through this staff meeting the counselors become better acquainted with the type of patients that can be best served in the Day-care program.

It is important for the counselors and the supervisors to attend this conference to understand better the function of Day-care. The majority of clients that are referred to Butler are done so with Day-care in mind, and yet our statistics indicate that a relatively small percentage of the referred clients are accepted for treatment on Day-care. Therefore, continuous attendance at this meeting makes the counselors aware of what would be more appropriate referrals. There has been a steady improvement in the referrals to the hospital since these conferences have been instituted. The counselors who attend regularly have referred more eligible clients and are more involved in the treatment process. The coordinator has continued to be the liason between the hospital and the agency and, through him more counselors have been attending the meetings.

The Butler staff welcomes the participation of the counselors at the meetings. The Butler personnel receives a better understanding of the agency policies as well as serving as a training service. Communications have improved, while the counselors have become enriched through their learning experience.

III. PHILOSOPHY OF DAY-CARE...DR. HUGH CRAWFORD

A. Evolution of Theoretical Framework

In the 1940's and 1950's the so-called "open door policy" began to be a matter of great excitement. Perhaps some mention at this point of the idea of the open door might be in order. For although as far as this hospital is concerned, it is a matter of history, there remain many hospitals throughout this country to whom the simple facts of our everyday life have stayed a mystery. The idea of the open door is not just simply a more liberal way of confining an individual to an institution. The opening of the door of the ward is a device by virtue of which, having been deprived of the physical obstacle of the door, the ward as a functioning unit must devise some methods of staying in contact with its members other than captivity. In the process of this ensuing effort certain fascinating discoveries are made. The relationship between the staff and patient changes. We find that these two people have lived in fear of each other throughout their contact. The one feared as a problem of control and the other feared to be over-controlling. When they meet on this new basis, it is really no longer feasible for the controller to order control, for the door is open and the anxieties surrounding the early phases of the opening of the door are quite intense. The realization that staff and patients were indeed engaged in a complex interactional pattern has probably been given greatest impetus by open-door philosophy, or perhaps more accurately by the mid-twentieth century philosophy of human responsibility which pervades the best hospitals. Actually some of the better studies have taken place on staff-patient interaction patterns in settings which are quite closed. In fact, one encounters a rather fascinating phenomenon; namely, that when the door has been opened long enough for staff and patient to be in a proper interactional pattern, the door can quite easily be closed, and this is seen to be meaningless. Dr. Stanton at McLean, Dr. Maxwell Jones mainly in England are outstanding examples in the field of study of these interactional patterns which will occur in people who are freed, like water, to seek their level. This evolution of these interpersonal techniques which have evolved both from the central body of interpersonal psychiatric theory and from the accumulated experience on open ward settings, has led inevitably towards the realization that the functional aspect of a hospital is not its walls or roofs or beds, but rather those activities that take place therein. When we have comprehended this notion, we are off and running, so to speak. Once you have opened that door there is no end to what you can do. You can have outpatients, inpatients, halfway house patients, night-care patients, day-care patients, occasional patients, continual patients. You can have patients in group therapy, patients in individual therapy, patients involved in continuous transactional studies, patients immersed in committees and groups. By the symbolic act of opening that door, you have opened the world of the patient to the democratic opportunity for choice.

So you see, that with the symbolic opening of the door to freedom of activity, we have produced in the patient the phenomenon of choice. Once again he is a choosing individual, a human organism in the natural state. Having produced this democratic phenomenon, however, we now have to provide those democratic facilities which foster that choice, protect it, and lead it towards a fruitful outcome for the individual. This is the basic principle of day therapy as practiced at Butler Hospital. In order to get more than just freedom of movement out of this freedom of choice, which has been so carefully won, day therapy in this hospital has become a definite attempt to emphasize the use of the day as a framework against which the patient can be seen. Just as in group therapy, occupational therapy, recreational therapy, psychodrama, etc., so with the day. Against the background of the day, an attempt is made to encourage the patient to project himself onto this framework and to encounter between himself and his environment the characteristic date of his functioning. Ideally there are certain requirements of this interaction: 1. One has to convince the patient of the value of such work. 2. One has to be prepared to assist him with the inevitable embarrassment and harrassment which may well ensue. 3. The framework itself must be a.) simplified so that in Rorschach fashion the patient maximally projects himself, b.) the frame must be stabilized, that is to say there must be 1.) some self-awareness in the staff, or 2.) some preparedness to see their errors as ground for work and without expectation of unjust or unnecessary disciplining.

The term "day-care" covers some more specific service in which the patient comes to day-care while, for example, he cannot afford hospitalization, or does not require hospitalization, or is not yet ready to accept hospitalization, or is being prepared to somewhat gently separate himself from the hospital, and in this hospital without beds, he receives daily care. Essentially, I want to present the central theme that this hospital uses a day therapy center as a therapeutic tool, and although this is primarily conceptualized as a service for people who do not sleep in the hospital, it is equally freely used by patients staying in the hospital and constitutes much more than a mere economy on beds.

The framework of the Day Therapy Center in this hospital is essentially the traditional framework of occupational and recreational therapy, with various subdivisions of these into domestic and scholastic, and various skills, such as printing, painting, carpentry, ceramics, weaving, and sewing. In this setting the patient is encouraged to seek significant emergence and progression of himself upon this human-type framework as opposed to a disease-type framework. That is to say, he is not encouraged to think of himself as getting better, but rather to think of encountering himself as he is, on the assumption that his symptoms are, so to speak, points of contact between his personality and his environment, but not of themselves constitute anything more than a warning light on the instrument panel of the particular implications of the particular adaptive mode in this particular individual. In this setting, symptomatic improvement tends to be rapid, with a minimum use of drugs. The program is growth-oriented rather than symptom-removal oriented, with the result that in younger patients the stay is not necessarily brief, ranging from a minimum of three months to one year. At the same time, however the adaptability of the Center is high and varies from that extreme to the other of the older patients coming as little as half a day a week.

All of the modalities of therapy are available during the patient's attendance, ranging from group therapy to individual therapy. The foregoing activities are presented and discussed at daily staff meetings with additional twice weekly discussions for more detailed presentations. These meetings are somewhat unique in that there is little discussion of medication, disease entities, or of any particular treatment concept or symptomatic progressions, but rather they are framed with an emphasis on the more simple human points of interest with regard to any given patient and his fears, the basic premise of this being that the focus of interest being placed at this level among the staff, this is reflected in the kind of interaction pattern resulting between the staff and the patient. Since our basic premise is that the more human the input, the more human the output, we are satisfied that this kind of conference has so far paid off in results.

Finally, in closing, there are many kinds of Day-care Centers. This is only one. There are Day-care Centers associated with hospitals and Day-care Centers incorporated in hospitals, such as ours. There are Day-care centers entirely separate; there are even Day-care Centers with beds. At first glance their heterogeneous nature would seem to defy description, but on careful examination, one finds that what does indeed link them all is preparedness to use a people-type of framework as opposed to a disease-type of framework. It is, therefore, my opinion, that we have in effect abandoned the "humane" notion of "helping" people, and keeping them occupied, and feel rather, that there is a certain essential, indispensable framework to human existence, which if adequately provided, will result in those adequate biological responses from the individual,which leads toward health.

B. Attitudes of Staff Toward Philosophy of Program

In creating a workable Day-care program, the evolution of psychiatric services has been constituted not so much by the discovering of new technical devices as the gradual uncovering of the framework of human activity, and that every major advance in methods of care has been based on these premises - that technical activity produces technical results, and that human results can only be produced from human activities. By being involved and dependent on human activities, we are faced with the realization that the staff and the patient are engaged in a complex interactional pattern which was given its impetus by the open-door philosophy and mid-twentieth century philosophy of human responsibility prevading hospitals.

As was described above, in the job definitiion, the staff requirements in this Day-care project differed from the traditional concepts for personnel dealing with custodial care cases. Since the ancient philosophy of controller was discarded, the staff had to discover and define for themselves a basis for leadership and an attitude harmonious with the philosophy of choice. Each member of the Day-care staff was interviewed to learn of his attitude toward the Day-care program. The staff is unanimous in its understanding of its unique role, and consistent in its desire to achieve further awareness.

One staff member, who has been at Butler for a number of years and witnessed the various changes in the philosophy of the Day-care unit, commented positively and enthusiastically on the new approach. He felt that for once it is not important what the patients do, or create, or how they seem to behave, but what is important is that they actually do behave, interact and adopt an attitude. He stated that when patients come to work with him they may have a chip on their shoulder, or be hostile, but he ignores their behavior and quietly becomes a part of the environment. Gradually, after working on a project for two or three days, the patient becomes aware of his presence, communicates with him, and makes inroads into the learning process. The patients build themselves around Day-care. Some choose one thing, some select another. They enjoy the freedom of choice. It is interesting for the staff to watch the patients develop within the framework of the program. "You can't force a patient, or push him to enter an activity, you have to let him make his own choice. You don't put a patient on a schedule or he will rebel. When the patient first comes, he observes the others, and then he reaches for what he wants."

In working with patients, he treats them naturally and intuitively. He tries not to have favorites, but realizes that some patients react differently to the same situation. He tries to "measure" his personal involvement knowing that psychiatry is the doctor's role. He feels that his prime function is to be available to the patient, and by being available a relationship can be established from which growth and trust emerge.

The staff personnel appreciate the free floating atmosphere and the lack of authoritarian controls. One worker claimed that she was growing and learning while she was working. She had worked in other institutions, but had never experienced the satisfaction and joy of self-discovery along with the patients. She finds each new

patient a challenge, preferring to meet him on neutral grounds. She does not like to study case histories in advance of meeting the patients, wishing to judge them on her first impression and initial contact. This way she is not influenced by the patient's stormy past. She guides her actions by the advice of the psychiatrist, and tries to make each person in her midst feel at home. She is impressed with the solidarity of the staff. They get along well together, all working for the ultimate good of the patient. She stated that Day-care could exist without any facilities as long as the philosophy of a human framework of interaction endured, but realizes their interdependence.

One young lady asserted that Butler Day-care was "very twentieth century in its whole approach. We are trying to continue community life through a group process." She stated that patients come to be observed by the staff, and to observe themselves in such a way that they act naturally. Certain people will reject them, and hopefully, they will realize their behavior reactions led to rejection. This is hard to accept but when they realize they are structuring the situation themselves, that they are to blame and no one else, they begin to note a change. They were able to say to themselves, "I'm rejected because I asked for it."

In this biological framework the patients make choices. The more they stop to think about their choices, and why they are exercising them, the more insight they will gain. Insight can be a painful process, but it is necessary for healthy living. The patients accept each other as they are. Some have eccentricities

and idiosyncrasies, but the other patients accept these mannerisms. Whether there is acceptance or rejection there is a learning process, and in learning there is growth.

Another staff member is impressed with the philosophy of freedom, and the feeling of spirit that he associates with the Day-care program. He feels that the project functions within a loose framework; that the staff is present to set up a therapeutic situation; together the staff and patients work against conformity and rigidity to achieve goals. Group discussions involve several different personalities which interact with each other. All this creates therapeutic situations which stimulate cooperation. There is no negative or positive value placed on what is accomplished. Patients are simply encouraged to find themselves through the variety of channels open to them. They are helped along toward their goals by the staff. Each person pursues his own interest in the hopes of developing his potential.

The director manages to dissolve many of the anxieties of the staff. He makes them feel comfortable in the transaction that takes place between personnel and patient. The staff is removed from the bureaucratic pressures of most organizations and can thrive.

Another member of the staff described the program as a somewhat nebulous arrangement that is more satisfying to some patients than others. He feels some people are disturbed by its lack of direction, and these individuals need more attention. "They come expecting to find a daycamp with things to do each hour, and they may find themselves searching too eagerly." Most people love the program, become attached to the staff, and learn to express themselves within the framework. He continued that some patients are not as articulate as others, and can not express themselves. The environment of Day-care enables them to express themselves through actions and relationships. He said that even after he had arrived, and spoken with the director, he didn't have a clear conception of Day-care. "I couldn't understand what transpired here until I lived with it."

The final staff member interviewed, stressed the fact that the program could prevail in its present form without any of the therapy aids constructed to provide dimensions. As long as there was a building, or even a large room, in which human beings could interact with one another, the Day-care program could function. People learn how to get along with each other in a socially acceptable way. There is a protected environment offering comfort and security and "the only conformity here is decency." People have choices presented to them all the time - they either accept a choice or ignore it, but their habits incline them to do one of these things; one may be unacceptable, and they begin to grow when they discover they have other choices that they never used before. Although there is no hierarchy here, there is a social structure that has been erected by the patients themselves. They have their own favorite staff member, their own companions, or their own cliques. However, they have successfully or unsuccessfully established their own place in this protected society by their free choice and independent thought.

In discussing the staff, the director stated that detailed presentations of the patients are discussed at staff meetings.

These meetings are somewhat unique in that there is little discussion of medication, disease entities, or of any particular treatment concept or symptomatic progressions, but rather they are framed with an emphasis on the more simple human points of interest with regard to any given patient and his fears. The basic premise of this being that the focus of interest being placed at this level among the staff, is reflected in the kind of interaction pattern resulting between the staff and the patient. Since our basic premise is that the more human the input, the more human the output, we are satisfied that this kind of conference has so far paid off in results.

IV. METHOD OF RESEARCH

A. Observation

In order to submit this report, the research worker spent several months of careful observation of the Day-care program. She began at the hour the patients arrive in order to observe the beginning of the day. She was aware of the interaction between the patients and the staff. She spent several entire days in Ray Hall, in each of the therapy areas, becoming familiar with the entire gamut of activities. She watched cooking classes, sat in the classroom, and participated in the recreation area. On certain days, when the director was absent, she attended the program, at his suggestion, to observe the difference in the behavior of the patients and staff. She visited the program when special functions were held such as entertainment by the various patients and the Christmas party. Through the continued observation she became completely familiar with the program.

B. Weekly Staff Meetings

The research writer attended the formal and informal staff meetings to observe the method of learning by the staff. She observed the interaction between the personnel, the role of the director, and the function of the DVR coordinator. She was able to ask questions and participate in the meeting.

C. Staff Interviews

Perhaps one of the most valuable ways of gathering information was the experience of interviewing each member of the Day-care staff.

At first there was some resentment in the probing questions that were asked, but everyone participated and some of the staff members recalled the interviewer at a later date to add relevant material that they had overlooked at the time of the interview. They became interested in the project report and began thinking about the environment they were helping to create.

D. Patient Interviews

In order to ascertain the interest of the patients in the program and their degree of understanding about the philosophy of Day-care, it was necessary to interview the patients. This was a most satisfying experience. The first few patients interviewed were shy and guarded, but gradually they all showed an interest in having "his turn." It was noticed that after they were interviewed, the patients exchanged notes with each other about what was said during the interview. To many of them, it was the first time their opinions had been asked about a program,which greatly concerns them, and they were quite verbal. As in all situations, some patients were more articulate than others, but every patient that was approached cooperated.

E. Case Records

Certain case records were read for the purpose of getting data for tables and for compiling the diagnostic categories. They also supplied background material in presenting examples of cases.

F. Meetings with Director

For a period of months, the researcher met weekly with the project director to understand the philosophy and workings of the

Day-care program. His permission was granted in setting up interviews with the staff and with the patients. He also was helpful in introducing the researcher to the Day-care staff so that her position was comfortable while observing activities. He outlined the draft of the report, contributed ideas, furnished material on historical literature, and drafted and executed parts of the report.

G. Additional Interviews.

Additional interviews were conducted with many of the DVR counselors to discover their feelings about the Day-care program. The DVR coordinator was consulted and his services were given in compiling statistical information. Psychiatrists on the staff of Butler were interviewed to provide their criteria of acceptance for patients. The social worker and the psychologist were also interviewed to establish their respective roles in the Day-care project.

V. ANALYSIS OF PATIENTS

A. Typical Day in the Life of a Day-care Adolescent

The bus takes the patients directly to the hospital. The adolescent under discussion is a fifteen year old female patient. She arrives at the hospital at about 8:30 a.m., having met two friends on the bus. They check into Ray Hall, and join the already forming group around the dining room table. A huge pot of coffee is brewing and everyone helps themselves. Members of the staff are part of the group, and someone relates an exciting event that occurred the night before. This leads to a discussion about sporting events and the baseball scores of the previous day are discussed. One of the newer patients comes in with a pattern for a dress that has become quite a fad. Our adolescent decides that she, too, would like to sew the same type of dress. She discusses it with the staff member who works in the sewing area, and together, they decide what fabric the patient should purchase. The newspaper is available, and our adolescent reads the headlines, and then decides to spend the morning in the classroom.

Upstairs she finds that she is not alone. Several other adolescents have selected to spend the first hours of the morning in study. At first she is disappointed to have to share the instructor with the others, but gradually she becomes involved in an art discussion. One of the patients has brought in an art book on the impressionists which leads to an interesting argument on modern art and pop art. Our patient had planned to study her French and she takes out her book, beginning to translate. Once she becomes absorbed in her work, another patient, a noisy boy of about nineteen who is busy shocking the others with obscene language, enters the room noisely. The instructor does not have to reprimand him. The patient and others remind him that he is in the classroom, that they are busy and not impressed with his vocabulary. No one snickers at his language; they ignore him; and he gradually quiets down and becomes interested in studying distant islands on the globe. The schoolteacher comes over to the patient to see if he can be of any assistance, and together they work out difficult passages in the lesson. Although he is surrounded by many patients seeking his support, he is able to give of himself to each patient.

As the morning passes, the patient becomes bored with her studying, and seeks other activities. The daily round of varied activities at the Day-care Center give each patient the opportunity to exercise his choice. They are available to keep the patients busy and occupied, and most find it helpful. In the living room area, our patient meets another teenager, who is looking for something to do, and they decide to bake cookies for the afternoon snack. Permission is granted, the task is begun. Each patient has decided exactly which recipe she wants to bake, and of course, they arrive at different decisions. After a minor dispute, and a careful survey of available ingredients, a compromise is reached. They have decided on an alternative recipe. Together they make and bake the cookies utilizing the facilities of the kitchen, with an occasional visit from other patients, all eager to sample the finished product. When the baking is finished, they clean the kitchen, being careful to return all the utensils to their correct places. They are content with a feeling of accomplishment.

At noon, it is time for lunch. Some of the patients bring their lunch and purchase a beverage, eating in the dining room area. Staff members might join them. Other patients prefer to buy their lunch in the adjoining hospital Coffee Shop. The shop provides a change in environment, and our patient enjoys eating here with her friends. They are friendly with the volunteer Coffee Shop worker, and tease her about her slow service and weak coffee. The Day-care director comes in and joins the group, speaking informally with the patients and personnel. One patient tries to attract more of his attention by spilling his food, and becoming conspicuous. He is silently rejected, but the others are deeply aware of his actions, and he is conscious of what he is trying to do. Our patient becomes so involved in the Coffee Shop activity that she asks if she may work there for an hour during the busy part of the afternoon. She is given permission, and the volunteer teaches her how to use the cash register and to make change.

A group of beatnik-looking teenagers are playing in the living room, their lively guitars echoing throughout the building. There is a mass exodus from the Coffee Shop and the other patients, including our teenagers, join the group. There is a slight dispute about one of the guitars needing tuning and sounding flat, but before long, there is a reconciliation. One of the staff members sits on the floor with the group, and patients start requesting their favorite folk songs. An informal sing has taken shape, and a happy, relaxed feeling pervades the atmosphere. The group does not by any means include all the patients. There are those individuals who prefer to continue their sewing or painting. Some adolescents sit at a bridge table and play scrabble.

Gradually the group disperses into little groups. It is almost time for our patient's group therapy session to begin, and those patients in the group are beginning to show their eagerness and some anxiety. Others not in the group appear to feel somewhat isolated and left out, but they may be receiving casework, individual therapy, or might even be included in another group. Our patient slithers over to a young, new male patient whose attention she has been seeking. His disinterest does not seem to thwart her, and she continues to heckle him. It is almost two o'clock; time for group therapy to begin. The Assistant Director takes attendance of those in the group, and rounds up a few stragglers. She leaves the room, the patients scurry to get the seats next to the psychiatrist. Only two of the ten have been successful, and our patient is one who had to resign herself in sitting across the room. The psychiatrist allows the discussion to develop through the initiative of the patients. On the whole, the groups are arranged to serve people with similar problems or similar age groups. This group is for adolescents; there is an underinvolved person, an overinvolved, a manipulator, and an obsessive meticulous person; persons with all affect, those with all intellect, but all trying to gain insights into their behavior and personalities. Our patient appears a bit sullen; she has not received much attention and becomes uncommunicative. The session is over too soon for some, not soon enough for others.

Our patient returns to the Coffee Shop, where she will help wait on customers. She becomes friendly and chatty. She enjoys working behind the counter, feeling a sense of importance. She learns to make drinks on the blender, and when the afternoon rush has subsided, she offers to stay and help clean. However, it is recreation time, the one organized activity that is compulsory for all patients. She would prefer to stay in the Coffee Shop; perhaps she wants to be free of the group for awhile, but the schoolteacher has invited her to walk over to the gymnasium with him, and she knows that she should go. Once in the gymnasium, the two teams form for volleyball. Some of the patients are encouraged to join the game; our patient takes a place on the court and begins hitting the ball. The recreation period is important because it gets all of the patients out on their feet, provides exercise, and gives them a chance to get rid of some of their hostility and energy. All of the patients participate differently according to their personalities. Some become very competitive and annoyed with less enthusiastic members of the team; some merely stand on the court and pretend to participate; and some find it very difficult to relax and lose themselves in the activity. It is interesting for the staff to observe the patients during the recreation activity and be aware of their interaction.

When the ball game is over, the patients and staff return to Ray Hall, where they have a late afternoon snack. They have coffee and the cookies which were made by our teenagers. The group sits together talking over the day's events and planning for the future. The staff remains with the patients until they leave the Day-care center at 4:30. Some patients leave in groups, some are picked up by parents, and some walk home. Our teenager leaves on the bus, enriched by her experience of the day, having undergone some of the stress situations the group organization has created, and more aware of how she copes with these stress situations, how she faces rejection and with some ideas of how to handle it.

B. Client Selection...Who Needs and Benefits from Day-care

The Tables accompanying this chapter point out the disposition of the referrals and the results of the evaluation of the DVR clients. In looking at the Tables, we see that the total number of clients referred during the five-year period of time was 932 clients, though only 408 clients complete some phase of psychiatric treatment at the hospital. This is less than fifty percent. There were a few clients who were referred for treatment on the Day-care project who never followed through and simply dropped out. There were a substantial number of clients, 162 to be exact, who were referred for an evaluation, for whom an appointment was set up, but who failed to appear. However, these factors do not account for the wide discrepancy between the number of clients referred, and those actually accepted for treatment.

As can be seen in Table 3, in the case of the adolescents, in one period of time, from June 1, 1960-November 30, 1962, 321 youngsters were referred to Butler Hospital for evaluation. Of this number only thirty percent ultimately received treatment in the Day-care center, so that in the beginning stages, when enthusiasm was higher, there were still a large number of referrals being rejected for the program as unsuitable or inappropriate.

Of those groups that were not recommended for psychiatric treatment at Butler, a variety of reasons were given. In some cases it was deemed practical for the youngsters to remain in school; vocational training was thought more appropriate for others; some were referred back to their counselor for counseling; some were felt to be more interested in seeking employment; many were considered lacking the proper motivation; others were products of social problems and environment which the Day-care could not improve, some were mentally retarded requiring other facilities in the community; and others seemed generally disinterested in involving themselves in a therapeutic situation that would change their position and behavior.

Table 3 shows that there was a sharp decline in the number of adolescent referrals after November 30, 1962. In the two and one half years remaining in the project, only 221 additional adolescents were referred, or 100 less than during the first period of the project. It would seem that the DVR counselors were discouraged by the lack of acceptance of their clients and were using other facilities in the community. Also, during this period of time, it is worth noting, that DVR ran out of funds and was accepting fewer cases, so that could be some explanation of the drop. However, there does appear to be some confusion on the part of the counselors and some discontent on the part of the psychiatrists about the nature of the referrals.

When the project first began, in 1957, DVR considered the Butler Hospital its "psychiatric arm" and referred many cases for evaluation without regard to acceptance or rejection on the Day-care program. At that time, the staff was oriented to working with DVR clients and, furthermore, needed them for its survival. As the years progressed, and this new project replaced the former, the staff at Butler also underwent various changes. The new personnel did not understand the function of DVR, was not sure why all the clients were being referred, and did not have the same interest in the program. At the same time, the patient census at Butler was quickly increasing, and the hospital was no longer dependent on DVR clients for its treatment. Eventually, another staff at the hospital was developed which is more interested in furthering its association with the DVR agency, but in compiling this report, these changes in administration and policy cannot be overlooked. Another problem leading to confusion has been the constant change of DVR coordinators. During this project five counselors have assumed the role of coordinator. No sooner does one become adept at understanding the hospital policies than he leaves and another takes over. It takes each new coordinator a period of time to understand his position as liaison. He must help the counselors be selective in their referrals and he must interpret the DVR policies to the hospital.

From the Butler standpoint, there was a shift in the type of referral from DVR when the psychiatric consultants became active with the agency, and more emotionally disturbed adolescents and adults were being referred to private psychotherapists. It has been interesting to consider the motivational differences between referrals to private therapists and to Butler. Also, the DVR recently established a working agreement with the State Hospital, and thus, some patients that would have been candidates for Day-care, will be receiving the service elsewhere.

Motivation of the patient has continued to be a determining and controversial factor in the acceptance or rejection of DVR clients for Day-care services. There is a tendency among the psychiatrists to refuse for services a client who has had a long association with different agencies on the grounds that he has become too dependent on agency interference and wants to remain in this condition. The DVR counselors feel that these long term patients deserve another chance, that the opportunity on Day-care will provide a chance for the lost patient to try and find himself. Some psychiatrists assume the position that the very fact that the client is working with the agency reflects insurmountable dependency.

In recent months, through the reliability of the new coordinator, the relationship between DVR and Butler has improved. Some of the psychiatrists realize that the clients from DVR serve to enrich their practice, because the referral is one that would not ordinarily be seeking treatment at Butler Hospital. Furthermore, the weekly meetings have been reactivated and the counselors whose clients are being discussed are more in attendance.

TABLE 1

DISPOSITION OF ADULT AND ADOLESCENT REFERRALS BY DVR TO BUTLER HOSPITAL: June 1, 1960-Mar 31, 1965

DISPOSITION	ADOLESCENTS	ADULTS
1. Numbers of Referrals	542	390
2. Number of Evaluations	453	317
a. Recommendations for Day-care	150	109
b. Recommendations for Psychotherapy	69	73
c. Recommendations for Group Therapy	28	13
d. Recommendations for Casework	12	12
e. Not recommended	208	133
3. Did not come for Evaluation	89	73

TABLE 2

DISPOSITION OF ADULTS AND ADOLESCENTS REFERRED FROM DVR WHO COMPLETED PSYCHIATRIC SERVICES: June 1, 1960-May 31, 1965

DISPOSITION	ADOLESCENTS	ADULTS
COMPLETED BUTLER PSYCHIATRIC SERVICES		
1. Day-care	147	105
2. Psychotherapy	46	63
3. Group Therapy	18	11
4. Client Casework	4	4
5. Relative Casework	4	6
	219	189

TABLE 3

COMPARISON OF ADOLESCENT REFERRALS BY DVR FROM: June 1, 1960-Nov. 30, 1962

to

ADOLESCENT REFERRALS BY DVR FROM: Dec. 1, 1962-May 31, 1965

TIME PERIOD	NUMBER REFERRED
June 1, 1960-November 30, 1962	321
December 1, 1962-May 31, 1965	221
TOTAL	542

TABLE 4

CONCENTRATED STUDY OF AGE AND SEX OF PATIENTS ON DAY-CARE

March 1, 1964-June 30, 1965

	ADOLESCENTS (under 21 yrs.)	ADULTS
Females	19	33
Males	22	15
TOTAL	41	48

TABLE 5

NUMBER OF DAYS SPENT BY PATIENTS

March 1, 1964-June 30, 1965

	DAYS	AVERAGE NO. OF DAYS
Females	1,592	30.6
Males	1,334	36

In Table 4, we see a concentrated study of the age and sex of the clients on the Day-care program for the last fifteen months of the project. Of the total 89 patients, there were only 41 termed adolescents, and 48 were adults. However, it is worth noting that of those clients called adults, 11 were age twenty-five or younger, and another 13 were thirty or under. Therefore, if we consider young adults in the role of adolescents, we can safely say that another 24 clients fell into the adolescent category. The psychiatrists had a tendency to lump this age group with the adolescents because in most cases they were immature individuals who had problems going from the adolescent stage into young adulthood.

In the category of adults on the Day-care program, there are more than double the number of females than males on the program. This would be because it is more difficult for a male to leave his work to participate on the program, and would probably require more individual treatment such as psychotherapy. It is easier for females to be absent from the house during the day.

C. Analysis of Patients from their own Conceptions

How do the adolescents and adults on the Day-care Program feel about being here? What are their concepts about the program? What did they expect and what did they think they were going to do in a Day-care setting? Why do they think they are here? What are their hopes for the future, and what do they hope to accomplish on the Day-care Program? Most freely admitted that Butler was a place where one could go to receive help with his emotional problems.

When asked why they were attending the Day-care Program, the clients gave various responses. Some stated that they were referred by their DVR counselor, and there was nothing else to do. Most had a clearer concept of why they were in need of help. One eighteen-year old girl felt that she was still suffering from "nerves." She dropped out of high school, was unable to continue due to her emotional condition, and was not ready for work. She dreaded the thought of remaining at home..."staying at home would be worse." She felt that the Day-care center provided all of the functions of a "hospital or a rest home." There were doctors to answer your needs, nurses to provide medication, and someone to talk to when you were lonely. "You get everything as if you were in the hospital, but its a gradual breaking away from the hospital instead of just pulling yourself out into the world." She appreciated the idea of free choice stating "the choice here is very important and very wonderful. You don't feel the same every day and you don't feel like doing the same thing every day. If you don't want to come, you don't, if you want to, you are here. There is no one barring you in...you can talk or you don't have to...you do lots of things together if you like...before I came, I knew it would be a place where you made things in arts and crafts, but I didn't expect what I found...I like it here..."

A young male patient was interviewed regarding his reasons for attending the program. He commented that he was on Day-care "to attain a goal of getting better." His sister-in-law is a social worker who knew about the program and referred him to DVR for an evaluation. He stated that before he came he expected the program to be more organizdd, but he liked it the way it exists because he doesn't like organized programs. He felt that he was undergoing a useful experience because "I've been able to sit back and take stock of myself in a different perspective. Here you have the opportunity to be sick without censure. If you work with the program, and use it, it's a valuable experience. Since coming here, I can see myself clearer, and I've been able to develop better values along with my personality. There is control here, but you live within it...it gives you the opportunity to be here and be yourself...nobody knocks you down for what you say and do here, and when you say it, you're no longer afraid." This patient had a clear understanding of how the program could help him and was taking advantage of it.

A schizophrenic, bright, twenty-year old patient stated that he came to the hospital to become more accurate in his thinking. "I don't differentiate between sick and well, I differentiate between varying degrees of perceptive accuracy...the Day-care is more to me than a feeling of like or dislike. It is an essential that I have to have. I had to be allowed to expand in an atmosphere that wouldn't be offended by any hard to understand acts. There are certain individual parts of my character that I want to stress and make known; outside of Day-care this wouldn't have been allowed. ...a person has to work out his own problem. He can be sure none of the other patients will go out of their way to help him out. No definite solutions are given here...I'm just helped in my perceptive technique and with that I can more accurately observe what I am doing... it is not only important that I am perceptible to my own transmission, but also to the other individual so that negotiations can be made on a common plain of interest...I think that if a person is allowed to develop and intensify his will, and direct that will toward a profitable goal, a big step has been taken toward the door marked exit."

Some patients are not as articulate as others. One young man gave a rather superficial reason for coming, "I heard about the program through DVR counselor, I didn't expect to find anything much but a place provided which would offer me a new outlet for growing up. I was looking for a new custom of behavior and I didn't expect to find much, but I wanted to come." However, this patient is very talented, and is writing a short story describing his weekly trip to Boston on the New Haven Railroad, he was in essence giving an impressive description of his reaction to the philosophy of Day-care and his concept of his identity to the program. He begins his essay "In my approach to the gloomy edifice, I feel confident but unknowing of its new qualities in traveling,'commuting which will become a more legitimate and easier fashion from Providence to Back Bay, Boston in my concrete plans to get established in my solely elected world, the arts...The coach pulls away with a slight jerk and I look out the window at the changing scenery. I am finally on a new adventure to a newer life."

A twenty-year old female patient recalled that she had been hospitalized as an in-patient for a few months and upon her discharge, it was recommended that she enter the Day-care program. She resisted it, continuing to remain at home daily, doing nothing. A few months later, her psychiatrist prevailed upon her to try the program. She had extreme withdrawal tendencies and personality conflicts of identity, according to her own words. She was by nature lazy, she claimed, but she had become "sick and tired of staying at home every day." Once on the program, she became aware of the "intra-personal relationships opposed to the personal relationships that existed on the in-patient unit...showing abnormal behavior is all right, but it won't attain the attention the patient desires." She continued discussing her feelings about rigidly organized programs and how displeasing to her they were. "Butler's Day-care program is a formless form; there is a structure, but nevertheless, you are not programmed. It all depends on the day as to how I feel about participating in activity. For example, I don't like being a part of the cooking classes, but before I know it or realize it, I'm in the kitchen whipping something up with the others...it just happens."

Another young lady, twenty-four years old, also a former in-patient, admitted that she, too, was opposed to entering the Day-care program at her discharge from the hospital. "I didn't like the idea; it sounded like a kindergarten environment. The whole concept sounded juvenile and childish...I came for awhile but I became upset by the other patients. I didn't take part in any of the activities...I stayed at home awhile and realized that I still had problems with people so I came back with a different attitude. The fact that the program is not elaborate is beneficial; there is a warm, friendly atmosphere provided...I felt at first that this would be a loss of my dignity. I felt that I was a failure. I had failed in everything. I was very defensive...I was afraid of anger and hostility. Here I came to realize that someone can be angry with you and not hate you at the same time. I can now accept hostility although at one time I took it personally."

A disturbed twenty-eight year old patient informed the interviewer that he was at the program because he had been very sick. "I stayed at home for two years and I would not go out of my room. I am coming here every day, and I'm looking forward to every day just by getting out of my room and coming here. When I was in my room I was going backward more and more. I like the atmosphere here... like being with other people. Sometimes I just sit all day, but I'm with other people." I don't talk much, but I come every day, and I'm better since I've been here."

One patient, who had been seeing a psychiatrist in the outpatient department felt that he had not made too much progress in his individual therapy. He stated that "Day-care has really brought me out of my shell. I like it here because its a homelike atmosphere and I've never had a home. I feel an identity at last to where I fit in relation to other boys and girls, and to life in general. I don't feel lonely anymore and I have a sense of recognition. There are other people here like me; they have problems too, and we are working them out together. Without this I could never go into society. The patients don't look at you as if they are judging you."

One of the older, adult patients was more reserved about her feelings about being on the program. She recognized that she had been suffering in a state of depression, and she felt that she had improved on the program, although she was unable to give an idea as to how. She admitted that she felt somewhat isolated in view of the fact that the majority of patients were adolescents, and she didn't feel that she had anything in common with them. Yet, she stated, "they let you do whatever you want here. There is absolutely no pressure...the best thing about Day-care is that it is free from any tension."

Two male patients had negative reactions to the program in their interviews. One stated, "DVR wanted me to come here, and I didn't like the idea. I didn't like it in the beginning, and I don't like it now...I know that you are supposed to mingle with other people. At the beginning I thought we were supposed to do something, so I forced myself to go to the woodworking shop or to work on ceramics, but I didn't really like it. It didn't make me any better, so now I don't do anything except talk to the patients." The patient obviously needs the chance to work out his interpersonal relationships with other people, and through discovery and self-motivation, he stumbled on the realization that he was not coming to Day-care to become a woodworker or a ceramicist. These are byproducts which are effective with some patients, and less helpful with others. Actually this patient accomplished more on the program than he realized in his relaxed attitude with other people and his behavior in group activity. The other male patient was quite hostile and arrogant. He somewhat shamefully confessed that he liked the Day-care program, and that it "beats working or going to school. I can come any way I want, and I can be a slob all day...I don't know what is going on here. Sometimes I don't really feel like coming, but I come pretty regularly in spite of myself...you have a free atmosphere here; you can do whatever you want."

The patients all realize that they are sick; that they have problems; and that they are undergoing an environmental experience in some special kind of atmosphere. They all stressed the word "atmosphere," being deeply aware that they are being exposed to something different, something offering them the freedom of choice. They were pleased with the organizational framework of the program, and many were surprised that it existed in this unique way.

In relation to the patients' attitudes toward the staff, they seem in agreement that the staff understands their problems and is anxious to work with them. Only one patient commented that he didn't like certain staff members. He stated that "I just don't like them personally. They didn't do anything wrong. I like Dr. X. He is good to me, and he found out what was wrong with me...he's very good and he is willing to treat me." All of the other reactions were positive about staff interaction. Typical comments were, "The staff has more time for you here. They really spend time with you." "The staff is very cooperative; they are very nice and they try to help you." "The staff makes me very comfortable. They help you out." "I like the staff." A more verbal patient stated, "The staff tries to meet the needs of every individual. It is good to talk over your problems with them. People are people; they have a lot in common...at times I am very depressed but the staff helps me out...there is the woodworking shop, which is lots of fun because the man who runs it is very nice to be with...member of the staff are aware of each person's needs and sensitivities and weaknesses." A female patient added, "People here are interesting. The more bizarre the behavior, the more accepting the staff is...I am comfortable with the staff although I just float around." One young man said, "The staff is placed here with their experience; they lead their kind of lives and the patients are expected to work together with them and keep things under reasonable control." 'There is communication." A young lady is able to sum up the attitude of the group, "There are many people here...everyone is very nice; they let you be a person. The staff socializes with you, you get to know them better, they get to know you and you become friends." A male patient who had made good use of the program claimed, "if you haven't gone through an illness, you don't know the suffering that a person has had for his bizarre actions. Here they look at you for yourself. The staff seems to understand, and they don't judge you either. X has shared my illness with me, he understands me, and out of this comes friendship and understanding."

Security is the theme which dominates the patient's picture of the future. Most of them had experienced the difficulties caused by a lack of sufficient funds to provide adequately for a family life, and did not want to struggle with the same frustrations in their own lives. In their search for their identity, many of the patients who had been school dropouts, expressed a desire to return to school and graduate. One stated clearly his hopes to receive a college education, and even knew which university he was interested in attending. Another school dropout, had taken his high school equivalency diploma as soon as he finished Day-care, He wants to attend college and major in psychology. One girl stated that she had always wanted to become a nurse, and still did; however, it entailed returning to school and graduating. Perhaps wisely she said, "Right now I'll have to take care of first things first." A male patient stated, "I used to feel that self-confidence meant the ability to do anything with poise. Now I can see myself as I really am, I can see what I'm really doing, what is happening to me, instead of making up what is happening. I feel positive about myself. I want to go to college. As a result of the program, I feel stronger; it has been useful, giving me the opportunity to look at myself in an atmosphere enabling me to work with my problem, to see a situation, and do something about it." Only one patient had no idea what she wanted to do after leaving the Day-care program. One girl who dropped out of college expressed the hope that she would be able to return to her schooling. She stated that "I have more confidence and I know that my spirit has improved. I feel that I can now return to New York and either go to college or find an interesting job." Another patient hoped that he could return to his old job as a shipping and receiving clerk. He appreciated the help that he was receiving from DVR. One patient already had her job as a commercial artist waiting for her, and in fact, the day after the interview was conducted, planned to return to her work on a part-time basis. Another patient stated that he had already spoken to his DVR counselor about looking for a job, and the counselor had offered to help. The patient said, "I've had jobs in the past, but I never stick to them. This time I want to find one and stay with it. One patient had rather unrealistic desires to become a painter or an artist, but was not doing much about attaining his goal. Only one patient was concerned with earning money. He felt that so far he had no done much to help himself, and he looked forward to any job that he could find that would make him, perhaps, somewhat independent. One patient said, "after I leave Day-care, I'm going to again be in the proving grounds of society. Those grounds in which I unleash everything with my name on it. Whether or not my projections work or fail depends upon the soundness that has been built into them here. I'm planning to enter college, and I can't express to you the confidence that I have in myself. If I fail, tt will only be indicative of the fact that I left something out of the blueprints that have been drawn up here. It is not indicative of the fact that there may not be a workable potential within myself."

VI. PSYCHIATRIC AND SOCIO-CULTURAL ASPECTS OF DEPENDENCY

Who are the patients particpating in the Butler Hospital Day-care Program? What are their problems? What are they like? What crises in their lives led them to eventually seek help in a hospital Day-care program? Why were their lives interrupted? How do they differ from others? What characteristics in their family lives were common among them? What kind of childhood did they lead? This part of the report is an attempt to answer some of these questions. The psychiatric and socio-cultural aspects of dependency of these adolescents and adults are related primarily to family structure and its social implication. The material assessed has been derived from the case histories of the clients in the form of social background data. The material was obtained through the social workers from a relative of the patient involved, or in some cases, from the patient himself.

The material in this phase of the report concerns twenty Day-care patients who were involved on the Day-care project during the last months of its formal operation. They ranged in age from fourteen to forty-nine years, with seventeen of them under twenty-five years of age. Of these, five were eighteen, one fifteen, two were sixteen, one was nineteen, two were twenty, one was twenty-one, one was twenty-two, two were twenty-three, and two were twenty-five. Of those patients over twenty-five, one was twenty-eight, one was twenty-nine, and one was forty-nine. The group was divided evenly between males and females (10 males, 10 females).

The home environments of these patients were, on the whole, poor. These people had faced or were facing a disproportionate number of major family crises. One girl, for example, had been born illegitimately, was in an institution from birth until she was three years old, and was finally adopted by elderly, disinterested foster parents who felt that she should be eternally grateful for the material requirements they provided, although the home was devoid of human emotion and warmth. She found living in this atmosphere so unbearable that she constantly ran away from home, was picked up by the police many times, and finally chose a court commitment and institutionalization in a children's center rather than resumption of her home situation.

Other patients have endured similar family crises. Five patients, or twenty-five percent of those involved, are products of divorced homes. One additional patient has parents who have separated many times due to the constant philandering of the father. The mother actually sued for divorce, but there was a reconciliation. The father described himself to the social worker saying, "I am a rat." This patient had an entire life of chaos. His mother and father were separated for the first time before he was born. His early life was one of fighting and disruption. For a while he and his brothers and sisters lived with grandparents. They were shuffled back and forth between their mother and the grandparents. The patient was the oldest child and felt much of the responsibility for the lack of a secure homelife. One of his brothers was emotionally disturbed and was treated at another private hospital. Despite the instability and turbulence, the patient was an exceptionally able student. He was accepted at Brown University, where he hoped to develop his potential. He began having problems scholastically and socially, and it was suggested that he take a leave of absence and eventually return to school. He joined the Air Force where he had a severe breakdown and was hospitalized. After his discharge, he developed many obsessive symptoms, such as trying to possess every girl he was interested in, and driving automobiles at excessive speeds. He became a danger to himself as well as to others. Despite his high IQ and a great potential for contributing to society, this young man was committed to the city hospital. He had found the pressures of his past had caught up with him and had become too difficult to endure. An obsessional psychotic, the psychiatrist described him after several months on the Day-care program, "improved cooperation and insight; the same threats of acting out by pestering as before but he is increasingly aware of the intensity of his dependency needs and their relationship to his suspiciousness and also to some extent, of their gratification by admission."

Another twenty-three year old patient was an abandoned child and the product of divorced parents. He lives with his eighty-three year old grandmother and the alleged sixty-seven year old grandfather. The grandmother is full of infirmities, and both insinuate that the other one is not too sound or reliable mentally. The patient has lived with his grandmother since he was eight years old. She was called by neighbors who said that the youngster had been crying after being left alone for a long period of time. She immediately picked up the child, who lived with her since. At the time, the boy's own mother was out socializing with the man she married after her divorce. The patient never accepted his parents' divorce, desiring constantly the opportunity to live with his own mother. His mother, who has another child by her second marriage, claimed that her living quarters were too small to accomodate the patient, and that she could not stand his practicing music all the time. His father also remarried, but the wife is a wealthy woman who wants nothing to do with the patient, and, as a result, the son has been isolated from his father. There has been constant bickering among the grandparents, the patient's mother and her second husband, his father, and his second wife, and it was obvious that neither of the parents wanted him. Rejected by his parents, he became the major interest in his grandmother's life. The grandmother tried to give him a good home, but overprotected him and treated him like a young, incapable child. Even as he grew older, he was given no responsibility and was completely dependent. He attended a boys' school, where he was driven back and forth by his grandfather. So peculiar was the relationship that teachers at the school assumed that the boy's driver was a chauffeur. He had no friends, never participated in group activities; worked briefly in a credit company but was abruptly fired, which hurt his pride. He suffered a fall and was treated medically when it was discovered that he also had epilepsy. However, the medical recommendation was that he seek psychiatric help. He was suffering from the apparent infantalization of him by both his mother and his grandmother. He had no identity; he did not know where he was going, or where to turn.

One eighteen-year old male patient was living with his married brother and sister-in-law, a social worker, when he entered the Day-care program. His parents were divorced when he was two years old. He was separated from his older brother. His mother was forced to work, during which time he was taken care of by his maternal grandmother. His mother remarried. The patient continued living with her, while his older brother lived with the father. The mother became psychiatrically ill, refused to see the patient, or have anything to do with him. According to reports of social workers, up until that time the patient was a loving, docile boy despite the instability in his life. At the time of his mother's illness, he changed dramatically. He stabbed a boyfriend, he stole hubcaps, did poorly in school, and showed signs of becoming delinquent. He went to live with his father and step-mother, but this did not work. He did not fit in at all in his father's home. He had continuous conflicts with his step-brothers and step-sisters, did not like nor get along with his step-mother, and produced very poorly at school. During this time his own brother was away at boarding school and he felt very much alone. He was sent to other boarding schools and military academies, at all of which he did very badly academically. He was transferred from one school to another, remaining at each one a very short period of time. Finally, he dropped out of high school and joined the Army. His length of service was very short; he attempted suicide, was hospitalized, and received a medical discharge. He was faced with the reality of being homeless; he did not know where to go. His older brother, who had married a social worker, was a college student and agreed to have the patient live with him. In his new home, the patient continued his former pattern of behavior. He had childish outbursts and temper tantrums; he did not contribute anything to the homelife; he was destructive in the small apartment. He had never had a consistent homelife, and he did not know how to adapt to normal conditions. He never followed through with tasks he would begin; he never accomplished anything worthwhile. He became more and more disturbed by the futility of his rather passive adjustment and his tendency to acquire other psychopathic friends of both sexes. The interviewing psychiatrist, at the time of the evaluation of this boy, stated that "the ego structure, in spite of his flamboyant statements and behavior, was reasonably intact, and he is anxious to resolve his problems." Through the Day-care program, this patient managed to maintain consistent relationships with the staff and patients, and to gain self-confidence.

A twenty-nine year old, female patient was referred to the hospital Day-care program for an evaluation after a severe depression and anxiety. She had been hospitalized in a psychiatric hospital where she received electric shock treatments. She was referred to the DVR from the Public Assistance Department, appearing no stronger after her hospital stay. In learning about her past history, it was obvious that she had fallen into a socio-economic level well below her original expectations in life. She was the daughter of a lawyer who, by virtue of severe diabetes, was unable to provide adequately for his family financially and emotionally. He became severely ill; the family unit dissolved and the patient drifted into an environment considerably below her earlier one. At high school she had been a good student in the college preparatory course, planning to attend an art school after graduation. She looked forward to a career in art of fashion designing. Unfortunately, she became pregnant by her boyfriend, now her husband. When she was referred to the program, her husband was in the Adult Correctional Institute where he had been sentenced for eighteen months following a breaking and entering charge. He was unable to support his wife and child, and she was faced with a hopeless family situation. She had lived from one relative to another for the eighteen months and was faced with despair. When she appeared at the hospital for her evaluation, she was eager to find supportive help through an environmental experience. She was able to relate her situational difficulties in which she felt trapped, and at the time of her acceptance on the program, she was unable to cope with her helpless situation. Although she remained aloof while attending the Day-care program, her warmth and closeness toward other people increased. Her husband's release from prison interfered with her attendance, but it was felt that through her experience at Butler she had gained strength and insight.

A male patient eighteen years old was referred to the hospital after becoming severely withdrawn. He had been attending a private boys' school in Boston from which he was sent home to his father, after the housemother he had been living with found an incriminating note which he had written. The patient had instructed her to wet her hands and touch wires he had connected over an overhead light in her kitchen. The significant events in his family life are the story of rejection, hopelessness, and unhappiness. When this patient was four years old, his mother became mentally ill and was committed to a psychiatric institution. She remained in hospitals for four years, during which time the patient lived with an aunt in a distant city away from his father. When he was eight years old, he returned to his father's home. His mother left the hospital, remaining at home for short periods of time, but always returning to some psychiatric hospital. After these periodic admissions and readmissions, she had a lobotomy. The relationship between the youngster and his mother was chaotic. The mother did not trust the youngster and he didn't know why. She called the police department for every little thing the boy did. If he barely brushed her in passing her, she claimed that he had struck her. The boy began to fear his mother and disliked her. He could not please her. The father believed his wife, and much later discovered that her claims against the boy were untrue and part of her imagination. The parents finally became divorced, but the youngster was already disturbed. He was unable to continue his high school education although he was a promising student. The tension of his earlier years made living unbearable, and he was committed to a psychiatric hospital. This patient made good use of the Day-care program, receiving tutorial services enabling him to complete his high school education, and he received his diploma.

Another male patient, a twenty-two year old, came to the hospital after a life of confusion. His mother and father were divorced when he was a young child. He never knew his father.

His mother was an alcoholic. She remarried when the patient was about ten years old and had another child for whom she was totally incompetent to care. Her second husband eventually left her after five years of marriage, leaving the family financially in need of help. The patient tried to help his mother bring up his step-sister; he took care of his mother when she was in an alocholic stupor. His home was untidy and without leadership. He felt keenly responsible for altering the situation, but was in a helpless situation, unable to provide the necessary funds or support due to his own needs and dependency. He began to fear that he had homosexual tendencies, and was confused about his life's goals. It became impossible for him to remain in high school; he was unable to study, and he had to work. He first sought help in the out-patient clinic at Butler and received psychotherapy. He became a high school dropout, but was unable to find suitable employment. The psychiatrist treating him felt that it was necessary for him to become a part of the Day-care program, where he would become a part of a group with similar problems and where he could experience an environmental change.

Another twenty-one year old patient is also the product of a divorced home. His mother remarried and he never got along with his step-father, his own sister, or his half-sister and half-brother. This patient felt rejection from an early age, counteracting it by performing badly in school, academically and socially. He was always a poor student, forced to repeat the first grade because he was a behavior problem. He continued to present a problem to the schools and his mother. He was finally expelled in the ninth grade for refusing to conform with the rules of the school, and he never attempted to return for his education. He led a wayward life; undertaking many different jobs but unable to remain at any one for a reasonable period of time. He argued with his superiors, was defiant and hostile, and did not perform well. He bought himself an automobile and wrecked it completely. He joined the Army Air Force, but was discharged for not following orders. He was committed to the State Hospital for Mental Diseases on two occasions, for becoming a public nuisance and for purchasing and carrying knives and pistols. He had a violent temper which he displayed toward his parents and siblings and was obsessed with suicidal preoccupations. He was committed to hospitalization. As an in-patient, it was felt that he had made a substantial improvment despite his preoccupation and inappropriateness; he showed good ability to socialize and to control his impulsive behavior. It was felt that the Day-care program would afford him the opportunity to explore his abilities before again attempting to work.

A twenty-three year old female patient lived with her mother, an alcoholic, and her father, a mildly paranoid individual. Her mother's inconsistency and rejection caused her to have a stormy and destructive life. She was a poorly coordinated child, very withdrawn, and in her early life it was thought that she was retarded. She lived in fear of her mother, constantly being compared to her two-year younger sister, who was more attractive and brighter. As she became a teenager, she improved physically and academically and became a good student. She experienced inner turmoil, however, as she attempted suicide when still in high school. She temporarily came to terms with herself, managing to graduate college. During these years she became depressed, running away from college at one time, but always able to bring herself back to reality. There was always confusion in her home; she never learned to get along with her mother; and received hostile reactions from society due to her asocial behavior. Although she was a schoolteacher for a short period of time, her position was terminated due to her behavior. She became tense, despondent, and unable to live up to her potential. While on a trip, she was assaulted in an attempted rape, and took an overdose of sleeping pills. She was first hospitalized at Butler as an in-patient, where her physician reported that "her thinking is infantile and dependent, but not overtly psychotic...she needs Day-care for increased sophistication in social and interpersonal techniques."

Clearly, one of the basic functions of the Day-care program is its operation as a follow-up service to adolescents and adults who have had some kind of psychiatric help previous to their referral to the Day-care program. Of the twenty individuals under discussion, twelve of them, or sixty percent, have had some previous in-patient hospitalization. Three were confined in other nearby mental hospitals; two were hospitalized in the Armed Forces; and seven were formerly in-patients in Butler Hospital. Of these last seven, three were hospitalized at an earlier date, either shortly before their admission to Butler, or at another time in their life. Three additional patients were being treated at one time privately by psychiatrists. Therefore, seventy-five percent of this patient sampling had exposure to psychiatric treatment in some form, varying in degrees from a short hospitalization in an Army hospital after an overdose of sleeping pills to confinement in the State Institution.

In relationship to their siblings, four of these patients were only children, seven were one of two children, four clients had two brothers or sisters, one client had two adoptive siblings, one client had three siblings, three had four siblings. There are many references in the case histories where patients did not get along with his siblings or half-siblings. Age in relation to the client was not significant, being indiscriminately either older or younger. However, it is interesting to note that in the case of the patients with only one sibling, in five out of the seven patients, the other brother or sister had experienced greater success than the patient. In one case, where the patient dropped out of school in the ninth grade, the sister is a successful high school student. In another case, a sister is an airline hostess, and the patient always had the feeling that the sister was the favored child. One female patient, who dropped out of school in the tenth grade and found herself forced to accept subservient jobs, had a brother doing well in college. Another high school drop out has a brother who was attending college while maintaining a home for the patiant. One female patient, who did graduate college work, always felt resentment against her sister, who is more attractive and more brilliant.

The level of education of the clients being evaluated is worthy of discussion. Nine of them, or forty-five percent, did not finish their high school education. They cannot all be classified drop outs, however, because at least two of them became too emotionally disturbed to continue their schooling and it was hoped that after they successfully completed the Day-care program they would continue their education. One patient finished his high school training while on the program and hoped to attend college in the near future. Three of the patients completed their high school education but did not continue schooling. One of these three took a night course in business administration. Five patients, or twenty-five percent of those involved, were enrolled at college when their illness occurred and they were forced to leave. One of these patients was at Brown University where it was recommended that he withdraw from school for a while due to his behavior and inability to concentrate on his studies. Another adolescent began to have failing grades. He indulged in day-dreaming, was unable to concentrate, and attacked his roommate by holding a blank pistol to the boy's head. One young lady was attending a large university in another city when she became depressed and confused. She had a serious conflict about her education, undecided as to whether she should be at school or at work. She had no clear-cut goals or ambitions. Another female patient, who had a strong academic background, attempted suicide while attending summer school. Although a fine student, she felt unable to cope with her work any longer. All of these patients had histories of disturbing home problems or had experienced certain crises in their adolescent development, so it was not the pressure of college that caused their illness, but rather it was the pressure of their past performance or lack of performance catching up with them.

Two patients were successful college graduates. One forty-nine year old lady had completed an accredited art school and was successfully employed as a commercial artist at a fashionable department store. The other college graduate was a schoolteacher before her hospitalization. Her adolescent life had been a stormy one; she had previous hospitalizations before entering the Day-care program.

The over-all picture that comes from the clients' interests, activities and hobbies, is that there is a lack of any real direction or goal, and hence, a lack of any truly meaningful dimension to their lives. These clients, on the whole, are apparently floundering around, searching for something to give direction, meaning and security to their lives. They are at a loss when it comes to organizing their free time adequately. Some of them watch television and some play cards. One patient had a lifetime interest in music; he continued to travel to Boston to receive lessons and spent much time practicing and playing. He has even had small jobs in local bands, hoping eventually to utilize this skill in his vocational goals. Another patient is interested in linguistics. She spent many hours on the program translating ancient languages. There was a patient who played the guitar and painted, but he was not serious about his goals. On the whole, these people did not exhibit strong interests for activities. Many had spent years in a struggle to survive; some came from culturally deprived homes; some never really had a home; and some were too preoccupied with their illness to perform or explore the avenues of life.

Although a small sampling of patients has been studied, the histories and dependency features are indicative of the large number of patients on the program. The role of the therapist has been to make the clients understand his dependency and to readjust his pattern of thinking despite his past experiences. A discharge note from the Day-care center on one patient read "through insight into her problem she realized that her mother caused her learning problem. She made a number of very real working efforts at socialization and experienced considerable improvement in her ease in functioning and improved concentration, and found herself able to apply for employment. Her prognosis for the future is good...she has showed real personality strengths and continued motivation to seek a successful adjustment." In regard to another patient, a nineteen year old male, it was written "on Day-care the patient established his independence of the program by obtaining full-time work, by his increasing maturity, by his increased participation in interviews, and increased awareness of relationships between his difficulties and his delayed pscho-sexual maturation."

VII. PERSONALITY TYPES THAT CREATE MOTIVATIONAL PROBLEMS

A. Diagnostic Categories

In the accompanying Table 6, we have made a study of the diagnostic category of each Day-care patient admitted during the period of March 1964-June 1965. On the whole there are significant differences between the types of illness of adolescents and adults in only two major categories. It is interesting to note that fourteen adults, or twenty-nine percent of the adults categorized are suffering from psychoneurotic disorders, such as severe mood swings and depression. Only two adolescents are in this category. However, eleven adolescent patients, or twenty-eight percent of those involved are suffering from adjustment reactions which involve symptomatic reactions to situational or emotional conflicts. However, one wonders whether or not the differences noted above in the illnesses of adolescents and adults is more obvious than real. It is interesting to speculate on the possibility of the diagnoses being somewhat dependent on the doctor's expectations for the patient and his greater tolerance and permissiveness toward adolescents as opposed to adults. It is easy to recognize that many psychiatrists are reluctant to label adolescent patients with diagnoses which might be interpreted as serious disease entities and are more comfortable in using labels with fewer potential implications. The most dominant category in both age groups, however, is Schizophrenic Reaction. The most common types are schizophrenic reaction, simple type, and schizophrenic reaction, acute undifferentiated type.

TABLE 6

DIAGNOSIS OF DAY-CARE PATIENTS ADMITTED

March 1, 1964-June 30, 1965

Mental Disorder	Adolescents	Adults
Psychoneurotic Disorders	2	14
Schizophrenic Reactions	12	15
Paranoid	--	1
Personality Disorders	7	8
Personality Trait Disturbance	8	9
Sociopathic	--	1
Adjustment Reactions	11	--
Alcoholism	--	1
TOTAL	40	49

VIII. PROBLEMS THAT ARISE

A. Case Selection

After five years of administering the Day-care Rehabilitation Center for Emotionally Disturbed Adolescents, there are certain problems that have arisen. The first of these is the realization that the program had to include adults in order to achieve depth, diversity and sufficient number of patients. As pointed out elsewhere in this report, almost half of the clients referred to Butler from DVR were adults over age twenty-one. Yet, a very substantial number of these clients were under thirty years of age, which leads us to suggest that the adolescent group should be extended to cover at least those people up to twenty-five and perhaps even thirty. This would be a valuable help in the area of research. Many of the young adults referred were individuals who had not been able to adjust from the adolescent stage, others were college students who were forced to leave school by the nature of their disturbance, and some were high school graduates who had floundered around in various employment fields. These people were as much in need of the rehabilitation services as the adolescents.

The greatest problem in administering the Day-care program continues to be the matter of selection of patients. There has been a gradual improvement in the type of referral that is coming from the DVR agency, but the statistics are proof that a great many of the clients being referred are not suitable for any type of psychiatric treatment. Butler must either accept its role as an evaluation service for DVR, without regard to the type of clients referred, or it must establish some clearcut standards for the counselors to follow in making referrals. There are two points of view in this issue. The DVR counselors do not actually know how to plan for a client in many cases unless an evaluation has been provided. The counselor may think that Day-care is a possibility, or even refer to Butler in the hopes of having psychotherapy provided. The majority of counselors who refer to Butler do so with the Day-care in mind. The psychiatrists at Butler, on the other hand, are already overworked, and when they are burdened with evaluations that don't have psychiatric recommendations, they feel that they are wasting their time that could be spent with patients. The counselor has the problem, at times, of having to supply an evaluation for a Family Court case or a Probation Department referral and this further complicates the situation. As mentioned earlier, DVR is now recommending a great number of their clients to private psychotherapists rather than Butler, and it would be interesting to study the motivation of the counselor in determining where to refer a client. It would appear necessary for the future for Butler to more sharply define the characteristics of likely candidates for Day-care so that the DVR counselors and supervisors would be in a better position to make suitable referrals.

B. Other Problems

Another problem has been creating an atmosphere that adolescents could enjoy, but that would be beneficial. It has taken Butler five years to emerge with a pattern that is conducive to total rehabilitation. If the program is oriented along lines strictly for teenagers, it becomes threatening to the adult patients. The problem has been creating an atmosphere that would be comfortable for adolescents and adults. Also when there is a large group of teenagers that more or less "take over" an activity, that activity is shunned by the older patients. It has been necessary to maintain some kind of equilibrium between the adolescents and adults.

Creating an ideal staff presented another problem. Although there is much psychiatric literature on Day-care Programs, there is very little information available on staffing such centers. Butler experimented with various categories of personnel before it was satisfied with its present staff conditions. Although the present staff at Butler is enlightened, adequate and effective, some psychiatrists feel that there should still be a trained occupational therapist and more activity therapists. It has also been suggested that the director be a full-time director without other hospital responsibilities. One psychiatrist feels that the assistant director of Day-care should be a trained social worker or a group leader. Also there should be another schoolteacher on the staff, so that one could be conducting a formal class, and the other doing individual tutoring.

Another problem has been assuring the day-patient of his identity. In the hospital, the in-patient has his ward and his room, the out-patient has his weekly appointment hour, but the day-patients were in an obscure position. Butler has worked at creating an identity for the Day-care patient. This has been accomplished through its facilities as well as the framework that evolved. Day-care patients are a relatively new concept in medicine, and so their position is often confusing to their own families, friends, and the community in general. The function and purpose of the Day-care program has to be stressed through proper education.

One continuous problem has been arousing the interest of the community psychiatrists in the Day-care Program. Many have patients who could profit from these services if the contact was initiated. Further referrals from private psychiatrists would enrich the program by widening the scope of patients included. A few psychiatrists have used the program when patients are being discharged, and it has been used by one or two as an alternative to hospitalization. However, Butler has an associate staff of over twenty psychiatrists, and a relatively few avail themselves of this program. It has been suggested that if psychiatrists refer patients to Day-care through DVR, a means should be created for them to continue seeing the patient in private practice. If the physician refers the case to DVR for Day-care, he loses the patient completely. It would be more satisfactory if the patient could attend Day-care three or four days a week and still have an authorization to see the therapist one day a week or every other week for an hourly appointment.

In assessing and evaluating the five-year work on the project, we cannot overlook the problems encountered by the state of change at the hospital. Butler has been in a considerable transition with constant change in personnel and staff. The diverse concepts of the many superintendents and other psychiatrists led to instability and ambivalence. During the term of this project, the sociology consultant also left the project and his position has not been replaced. In spite of all this a cohesive and comprehensive program has emerged.

IX. OUTCOME AND IMPLICATIONS

A. Results

The most important result of the project is that through the OVR grant, Butler Hospital received sufficient funds to implement and establish a Day-care Center for Emotionally Disturbed Adolescents. Although for five years the hospital was dependent upon these funds for the operation of the program, the Day-care center has continued to function and expand after the OVR funds have expired. Through research and experiment, plans were formulated and discarded until a workable, flexible program evolved. It is one that can now function independently and be a valuable resource to the entire community.

The wide range of diverse patients that have been served in the five years prove the need for a Day-care center. It is used as an alternative to hospitalization for seriously disturbed adolescents and adults and as an intermediary service for patients who have been released from Butler or other mental hospitals are not yet ready to cope with the stresses of community living. It provides a gradual separation from the hospital, and through its many activities and loosely structured society, reintroducing the patients to the competitive world. In this capacity, it can be used for long term patients who have been in the State Hospital or other hospitals for a very long period of time and have to readjust to society. It can also serve to shorten the hospitalization period of other patients by providing a place for them to spend their days, although they can return to their homes at night.

Through the affiliation with the DVR, the hospital has gained insight into the workings of a state-federal agency. It has also added to its patient load by servicing patients that would not ordinarily be able to afford psychiatric help. The agency has benefited by being exposed to a psychiatric milieu. Those counselors who have acted as coordinators have greatly widened their knowledge of psychiatric treatment. They, in turn, have interpreted the Day-care program to others. The counselors that have taken advantage of the in-service training through staff meetings and discussions have increased their awareness of emotional problems. This will benefit them in their normal counseling positions.